ADULTS WITH SEVERE MENTAL ILLNESS

Criterion 1: Comprehensive Community Based Mental Health System

The plan provides for the establishment of a recovery oriented, comprehensive, community-based system of mental health care for adults who have a severe mental illness, including case management, treatment, rehabilitation, employment, housing, educational, medical, dental, and other support services, which enables individuals to function in the community and reduces the rate of hospitalization.

GOAL: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.

Description of the Organization of the System of Care

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) administers a recovery oriented, comprehensive, community-based system of mental health care for adults with severe mental illness through contracts with Kentucky's Regional Mental Health/Mental Retardation Boards. KDMHMRS works with Kentucky Medicaid so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible consumers.

To encourage the development by Regional Boards of a full array of clinical, rehabilitation, and support services for adults with severe mental illness within their regions, KDMHMRS uses two strategies within its budgeting process. These strategies are:

- Priority Populations
- Community Support Services

Since 1985, KDMHMRS has required Regional Boards to prioritize certain populations, including adults with severe mental illnesses, in their budgeting processes. Despite budget deficits and competing priorities among the various program areas and service initiatives, funding levels for adults with severe mental illness have been maintained. As new funds have become available, further development of an array of community-based services has occurred. In addition, sub-populations who are historically under or inappropriately served have been prioritized including adults with severe mental illnesses who:

- Have co-occurring disorders;
- Are homeless;
- Are deaf or hard of hearing;
- Are elderly;
- Are of African-American descent.

The Ideal Array of Community Support Services

To effectively meet the needs of adults with severe mental illness, KDMHMRS has worked with consumers and other stakeholders to identify and fund an ideal array of services that support adults with severe mental illness in the community. These are organized along six major components:

- **Consumer and Family support**
- **Mental Health Services**
- **Emergency Services**
- **Specialized Services for Adults with Severe and Persistent Mental Illness**

The narrative provided for Criterion One describes these key components of the comprehensive Community Support Services array, and presents State Perspective objectives for the coming year for their continued development. A list of Community Support Services in the ideal array and a representation of their current availability by region are shown in the following table:

Regional Availability of Community Support Services SFY 2006

	Region													
COMMUNITY SUPPORT COMPONENT	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9/ 10**	**11**	**12**	**13**	**14**	**15**
CONSUMER AND FAMILY SUPPORT														
Training and Advocacy		X	X	X	X	X	X			X	X	X		
Consumer Support Group		X	X	X		X	X			X	X	X	X	X
Local NAMI of Kentucky		X	x	X	X	X	X		X			X	X	X
Consumer Conferences	X					X					X	X		X
Peer Advocates/Crisis Response				X		X	X			X				
EMERGENCY SERVICES														
Emergency-Help Line	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Walk-In Crisis Services (8-5,M-F)	X	X	X	X	X		X	X	X	X	X	X	X	X
Mobile Crisis Services		X					X		X		X			X
Residential Crisis Stabilization	X		X	X	X	X		X	X	X	X	X	X	X
MENTAL HEALTH TREATMENT Medication Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Community Medications Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Outpatient Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Outpatient		X												
Continuity of Care	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Integrated MH and SA Services					X	X					X			X
SPECIALIZED MENTAL HEALTH TREATMENT														
Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wrap around Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Therapeutic Rehabilitation	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Supported Employment			X	X		X			X	X		X	X	X
Educational Services					X	X		X	X	X	X			X
Other Community Support	X	X	X	X	X	X	X		X	X	X	X	X	X
Specialized Int. Case Management		X		X							X			
Assertive Community Treatment	X										X			
Homeless Outreach	X	X		X		X		X			X			X
Payee Services		X	X		X	X	X	X	X					X
Supported Housing		X	X	X	X	X					X			X
Residential Support		X	X	X	X	X	X		X		X	X		X
Housing Development		X		X		X	X		X					X
Criminal Justice	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Health						X								
Aging														
Deaf/Hard of Hearing	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Brain Injury														

COMPONENT 1: Consumer and Family Support

Regional Perspective
The regional community mental health centers have reported in their annual plan and budget reports that:

- Eleven regions have Training and Advocacy initiatives;
- Ten regions have consumer support groups;
- Five regions have consumer run drop in centers;
- Nine regions have local NAMI chapters;
- Nine regions have a consumer conference and/or support other regional consumer conferences;
- Three regions have consumer peer advocates;
- One region has consumer peer volunteers;
- Seven regions have designated consumer staff;
- One region has Peer Support Teams;
- One region has a Recovery Network to support homeless SMI;
- One region practices ACT with consumers involved on planning teams;
- Thirteen regions have consumer involvement on board of directors/planning committees.

In addition, many Regional Boards reported that supporting consumer involvement in consumer conferences, the Mental Health Consumer Advocacy Committee, the Leadership Academy, and other statewide initiatives by providing transportation has heightened consumer access to knowledge and involvement in planning a consumer and family driven mental health care system.

State Perspective
Since the mid-1980s, KDMHMRS has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding.

The Department provides funds for a variety of statewide and local consumer and family support initiatives. Each has goals related to advocacy, research, discrimination, wellness and recovery programs, peer support, education and training, and operating support.

The **Mental Health Consumer Advocacy Steering Committee** is a consumer, family member and professional education and involvement function that the Department has supported for approximately fifteen years. The Committee provides a way for the Department to fulfill its Block Grant obligation to involve consumers in planning. It also provides a direct communication link to consumers, family members and professionals who are interested in the planning process for mental health services through the Department. Finally, it brings together grass roots organizations with similar missions to reduce duplication of effort.

Through its membership, the following services are provided:

- Provides consumer, family, and mental health professional education programs;
- Promotes discussion of upcoming and pending legislation of interest to consumers, families, and mental health professionals;
- Provides an opportunity for participants who are involved in the regional community mental health centers to report on initiatives in their regions and to learn about other regional initiatives;
- Creates an environment for members who have attended the Leadership Academy to improve their leadership skills by participating in the meeting process.

The **Commonground Training and Resource Center (CTC)**, a joint project of the Kentucky Consumer Advocate Network (KY CAN), and NAMI Kentucky, is a consumer run technical assistance

center designed for statewide training, information dissemination, and technical assistance. Activities provided by the CTC include the coordination of the leadership academies, provision of hardware and software support to KYCAN, NAMI and individual consumers and family members, technical assistance in planning, services provision, and internet technology. Activities proposed for SFY 2006 include:

- Continue the use of technology to expand access to the Mental Health Consumer Advocacy Committee;
- Initiate a program that uses multimedia to address issues of discrimination against consumers;
- Advocate for family and consumer technical participation; and
- Explore and use technology to provide cost effective service and consensus building.

KDMHMRS and the Regional Boards use a number of strategies to support consumer and family involvement. While funds are limited, a significant amount of block grant funding supports the operations of the statewide consumer organization, Kentucky Consumer Advocacy Network (KY CAN), and the statewide family organization, NAMI Kentucky.

Additional strategies will include:

- Encouraging increased collaboration between Regional Boards and KY CAN and NAMI Kentucky in sponsoring “Bridges” and “Family-to-Family” support groups;
- Continuing to provide reimbursement for consumer and family members to attend state and regional meetings, conferences, and other gatherings;
- Requiring that regional planning councils review plans submitted to KDMHMRS regarding block grant funds;
- Continue to encourage a consistent grievance process statewide;
- Continue to sponsor the Consumer Leadership Training Academy and Train-the-Trainer Academy. Two, three and a half day trainings are being planned that will be taught by consumer graduates of the first trainings. A facilitator from West Virginia CONTAC will also participate.
- A consumer has been hired to coordinate regional Leadership Trainings by utilizing the skills of 25 consumers who have graduated from Levels 1 and 2 of the training.
- Continuing to support the KY CAN Consultative Peer Review program.

The KDMHMRS and the Regional Boards encourage consumer and family member participation in planning, monitoring, and service delivery. To improve existing weaknesses and build on existing strengths, plans are to:

- Accelerate the involvement of consumers and family members in the Block Grant planning process.
- Encourage dedicated funding for consumer run services;
- Design programs and trainings that incorporate recovery principles;
- Implement Supported Employment Training to encourage hiring of consumers;
- Encourage the growth of consumer run services by dedicated funding;
- Create ways to increase statewide consumer participation and all planning events; and to
- Make Recovery Model training available to regional mental health centers.

While KDMHMRS and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain. These include:

- No dedicated funding for consumer run services;
- Few programs incorporate recovery principles;
- Perception of risk in hiring consumers;
- Limited number of consumer run services that can serve as “mentor” programs; and
- Persistent transportation barriers to attending meeting and other events.

COMPONENT 2: EMERGENCY SERVICES

Regional Perspective

- All fourteen regions have a 24 hour Crisis and Information line;
- All fourteen regions have qualified mental health professionals on call for emergency evaluations for psychiatric hospitalization 24 hours a day, 7 days a week;
- All regions respond within 3 hours to a request for involuntary hospitalization evaluation;
- Crisis Stabilization Units are available in 14 regions;
- Crisis Stabilization Case Management Services are available to 2 regions;
- Training is provided to law enforcement related to accessing emergency care in every region.

State Perspective

Beginning in 1995, KDMHMRS has made a concerted effort to develop a statewide network of Crisis Stabilization Programs. These programs, which primarily serve individuals with serious mental illness, can be home-based interventions or residential units and are a major factor in Kentucky's reduction of inpatient utilization. In SFY 2004, funding was allocated to complete the statewide network by having a Crisis Stabilization Program in each Regional Board service area.

The KDMHMRS Crisis Stabilization Coordinator supports the ongoing development and enhancement of the network by facilitating periodic meetings of crisis stabilization program director and training events.

KDMHMRS funds a full range of crisis services that include:

- 24 hour emergency hotlines;
- Warm lines;
- Walk-in Crisis Services;
- Mobile Crisis Services;
- Suicide Hotlines;
- Residential Crisis Stabilization Units;
- Overnight Crisis Beds;
- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations.

A major initiative was implemented in SFY 2005 with the Passage of HB 157 which mandates the establishment of a statewide behavioral health telephonic triage system to be utilized by local jails. This system is used to screen jail inmates at booking for mental health, suicide risk, mental retardation and acquired brain injury and to make recommendations about housing, classification and treatment needs. This is a unique program as no other state in the nation operates a system of screening and assessment through a partnership between community mental health and local jails.

During SFY 2006 KDMHMRS plans to focus more specifically on the development of standards and the identification of evidenced based practices as they relate to Emergency Services. In addition, KDMHMRS has included a specific performance based contract item related to emergency services programs in the contracts for the regional mental health and mental retardation boards. These steps are in line with the Departments focus on transforming the system of care and strengthening the safety net for persons with mental illnesses.

COMPONENT 3: MENTAL HEALTH TREATMEN T

Continuity of Care/Reduction in Inpatient Psychiatric Care

Regional Perspective
KDMHMRS allocated new CMHS Block grant funds during SFY 2001 to develop two outreach specialist positions to evaluate the effectiveness of Strategies to improve aftercare performance by Regional Boards. The Outreach Specialists focus on efforts to engage persons with severe mental illness who have either "served out" from a correctional facility or been recently discharged from a state psychiatric facility. Additional areas of focus for Regional Boards include:

- Ensuring outreach and seamless services to individuals in transition;
- Ensuring that relevant services are available and accessible;
- Maintaining linkages with discharge planners, family members and others; and
- Monitoring relevant performance indicators (appointment follow-up, hospital readmission).

State Perspective
The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is key to ensuring a successful transition from the hospital to the community.

Providing appropriate aftercare following a state hospital stay is critical to reducing readmission rates. The Department requires a Regional Board to provide an outpatient appointment within two weeks of a discharge. KDMHMRS also requires the provision of case management services to adults with severe mental illness who are discharged from a state psychiatric facility, are determined by hospital staff to be in need of case management service, and agree to receive this service.

The fourteen Regional Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient referrals. Some Regional Boards function as single portal of entry for some of the hospitals. Due to the uniqueness of the providers and each individual they serve, a need to re-institute regular continuity of care meetings between the respective hospital and local Regional Boards was identified in SFY 2002 and KDMHMRS staff initiated the reconvening of these meetings. The agenda for each meeting includes the following topics:

- Aftercare performance;
- Community Medications Support Program;
- Olmstead planning;
- Continuity of care systems issues;
- Consumer issues;
- KDMHMRS Performance Indicators;
- Other issues requested by participants.

During SFY 2005, KDMHMRS worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional MHMR Boards to develop a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need to develop these MOAs was identified to strengthen the relationships between the hospitals and the Boards. The MOAs include the contractual responsibilities each entity has to the KDMHMRS, but also defines and clarifies roles and responsibilities the hospital and mental health center have to assure quality continuity of care to patients that they both serve.

During SFY 2005 KDMHMRS has worked with the Kentucky Hospital Association, the Kentucky Association of Regional Programs (KARP) The Kentucky Sheriffs Association, State Operated psychiatric hospitals and Regional MHMR Boards to address the increasing reduction of private sector inpatient beds across the state. Over the last two years, there has been a reduction of over 300 private inpatient beds in the state. The consequences, both intended and unintended, of this fact, are of concern to KDMHRS.

Regional forums will be held during SFY 2006 to try to develop some local solutions to assure quality mental health services remain available to persons with mental illness in their local communities.

KDMHMRS strategies to reduce unnecessary psychiatric inpatient utilization include the development of residential crisis stabilization programs, responsive emergency services, assurance of continuity of care and the continued development of other community support services as effective alternatives for adults with severe mental illness who are in crisis.

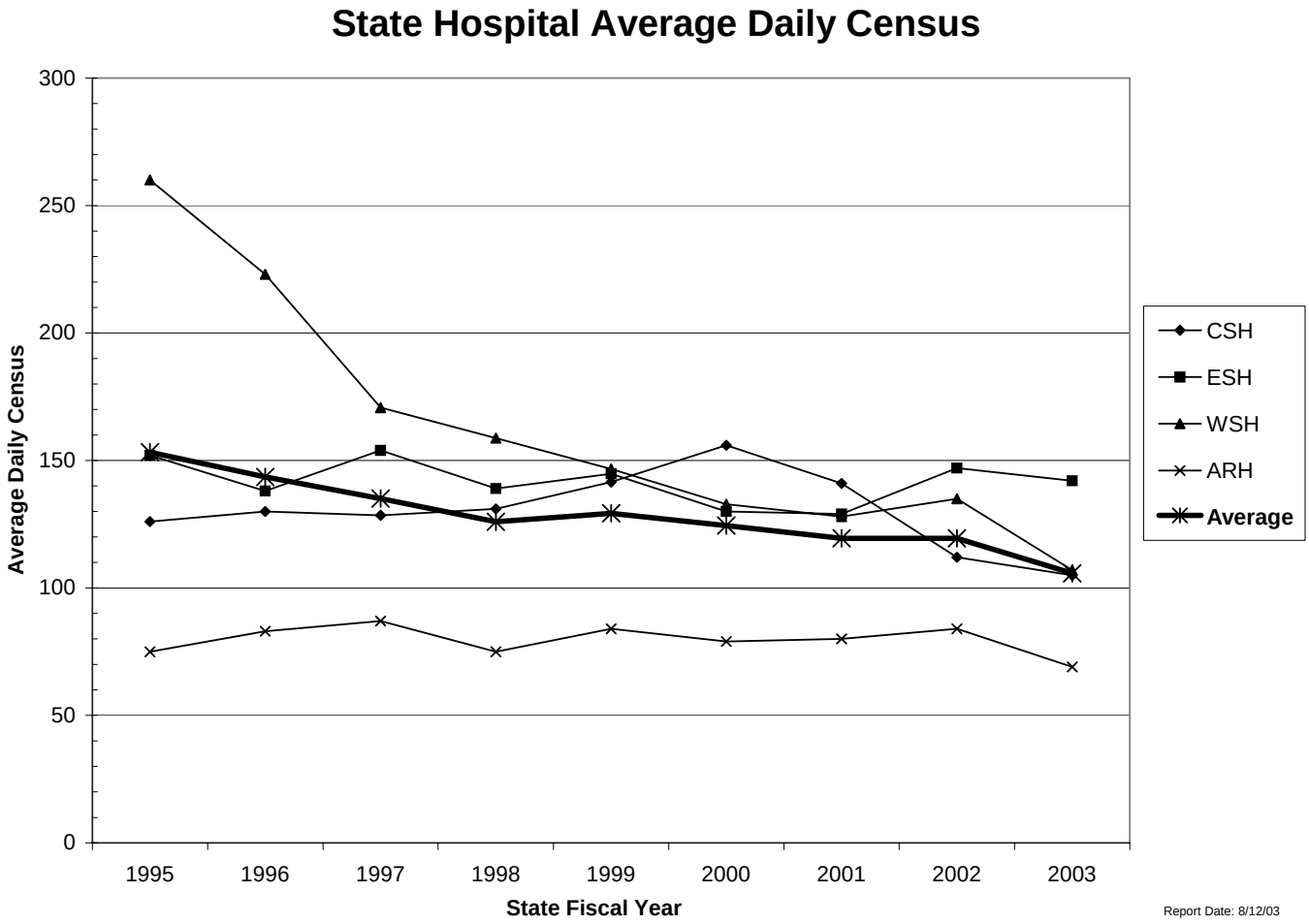
KDMHMRS has responsibility for the monitoring of the **Olmstead Initiative** in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of the representatives from the hospital, the Regional MHMR Board, KDMHMRS staff, and other appropriate stakeholders meet on a frequent basis to review transition plans that assure a smooth and timely discharge to the community for identified patients. Funds were appropriated during the 2002 legislative session to pay for individualized and specialized wraparound services to assure the community tenure for each of these individuals.

Kentucky has reduced its state hospital beds by more than 90 percent from the 7,689 beds available in 1955. From SFY 95 through SFY 98 the average daily census decreased by 20% at the four non-forensic state-supported psychiatric hospitals.

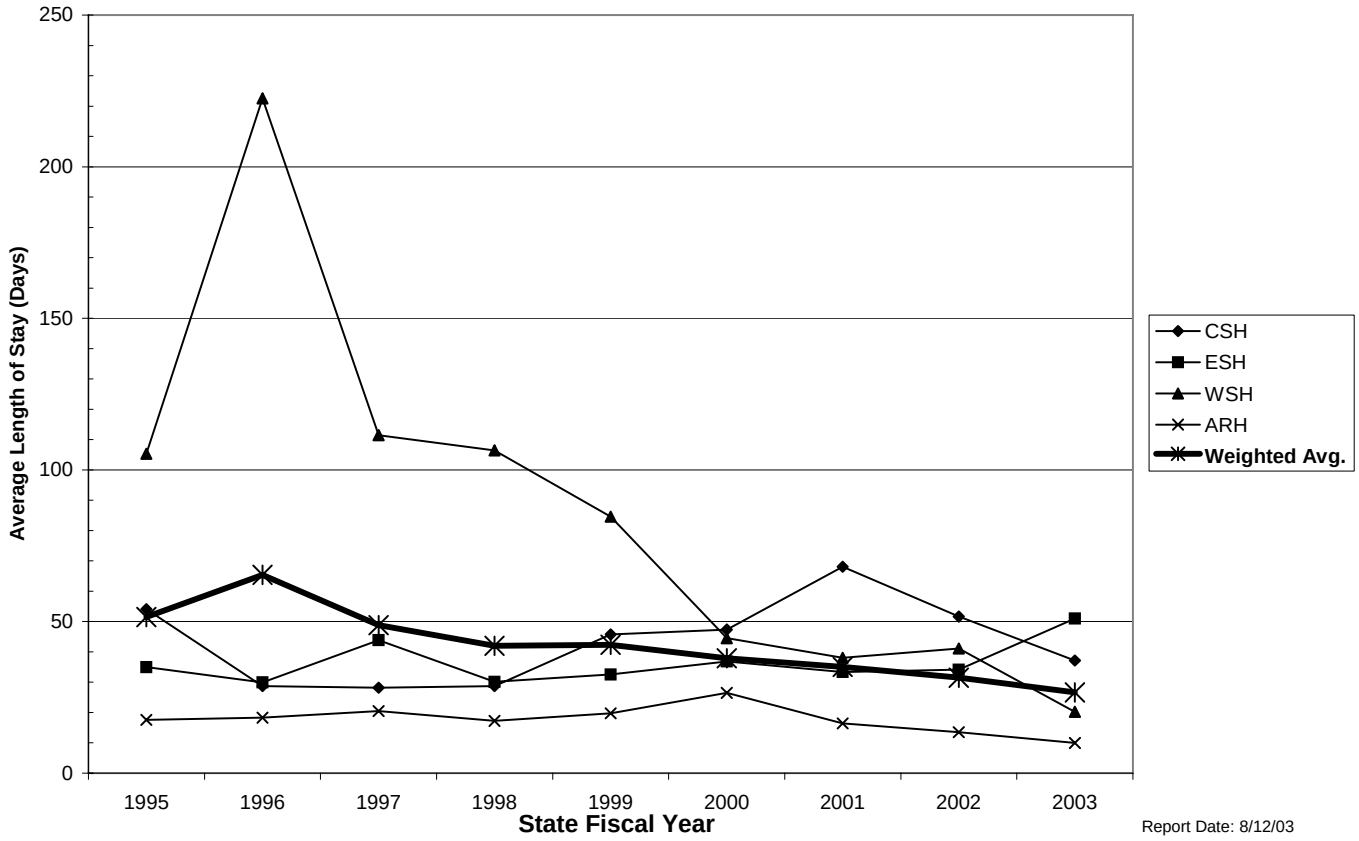
While lengths of stay in state hospitals continue to decrease, continuity of care issues remain. A number of challenges are presented to KDMHMRS and the Regional Boards. These include:

- Private psychiatric beds have been closing or are being converted to acute care beds which generate more revenue;
- The loss of private psychiatric beds in local private hospitals has placed a strain on state operated psychiatric hospital by increasing admissions;
- While crisis stabilization programs have existed in all fourteen regions by the end of SFY 2004, confidence in their appropriateness as alternatives to hospitalization remains low among most psychiatrists; Supervised residential options are sparse throughout Kentucky, thwarting efforts to discharge individuals with complex service needs;
- The unavailability of adequate funding for community-based services as alternatives to hospitalization remains a barrier to good continuity of care; and
- Reduction in funding to the state operated facilities impedes continuity of care.

The following two charts display average daily census and average length of stay within four state hospital settings.


State Hospital Average Daily Census
300
250
200
150
100
50
0
Average Daily Census
1995
1996
1997
1998
1999
2000
2001
2002
2003
State Fiscal Year
CSH
ESH
WSH
ARH
Average
Report Date: 8/12/03

State Hospital Average Length of Stay



Regional Perspective

Traditional mental health treatment in the form of individual therapy, group therapy and psychiatric evaluations are available in every region in the state. Budget constraints have forced some regions to scale back availability of mental health treatment services in less populous, rural counties. Additional areas of focus include:

- While all regions report having a system for following up with missed appointments, most recognize the need to provide assertive outreach so fewer appointments are missed;
- The majority of regions have a method to assure medication continuity within the agency when level of care changes;
- A shortage of professional staff, especially psychiatrists, has caused waiting periods for appointments to continue to grow;
- Continuity of care with inpatient settings and other community providers continues to be a major challenge in providing quality, holistic care;
- Screening for substance abuse disorders/co-occurring disorders occurs in every region with varying levels of comprehensiveness of the assessment process;
- The majority of regions provide opportunities for training regarding substance abuse disorders to their mental health staff.

State Perspective

The Department funds Regional Boards to provide an array of mental health treatment services. These services include medication management, individual therapy, group therapy, intensive outpatient services and integrated services for persons with co-occurring mental health and substance abuse disorders to non-Medicaid individuals with mental illness.

In addition to funding this array of mental health treatment services, KDMHMRS funds the **Community Medication Support Program (CMSP).** The Community Medication Support Program is a drug replacement program that provides low cost medications to the population who are living at a standard below poverty level and who do not otherwise qualify for federal or state assistance. The previous

success of this program is the result of a unique collaborative effort by the state operated/contracted psychiatric hospitals, the Regional Boards, KDMHMRS, and local pharmacies. The goal of the program is to assist adults in the community with a severe mental illness who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies, then the medications are replaced to the pharmacies by our state operated/contracted hospitals. The program is available in all regions. Eligibility for the CMSP is based on age (18+), income (federal HHS poverty guidelines and no third party payer sources), and KDMHMRS criteria of severe mental illness (diagnosis, disability and duration).

Current challenges faced include:

- Adequate availability of mental health professionals;
- Assertive Outreach is an identified priority across the Commonwealth;
- Evidence-based practice in clinical care is a KDMHMRS priority and is encouraged and supported at all levels. KDMHMRS is working with individual Boards to introduce the Level of Care Utilization System (LOCUS) and to introduce treatment guidelines for specific mental health conditions;
- HB 843, which established the Kentucky Commission on Services and Supports for Persons with Mental Illness, Alcohol and other Drug Abuse Disorders and Dual Diagnosis, issued their annual report. Included in this report were two significant recommendations related to co-occurring disorders. The Commission emphasized a need for increased initiatives related to cross-systems training for mental health and substance abuse professionals, as well as the development of more integrated service delivery systems, both at the state and local level.

Performance Indicators and Action Plans for this component are at the end of this Criterion

COMPONENT 4: Specialized Mental Health Treatment

Case Management Services

Case management is an essential Community Support Service because it coordinates an individual's service array, making maximum use of available formal and informal supports. Case management has been available through Regional Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Priority is given to adults with severe mental illness who have the greatest difficulties accessing resources and those with more intense service needs. Kentucky embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp) blended with the psychiatric rehabilitation model endorsed by Boston University (Dr. William A. Anthony).

Regional Perspective

A review of the information from the SFY 2006 regional plan applications reveals that case management services are available in all 120 of Kentucky's counties. Currently, over 7000 individuals are served by 200 case managers. Case management in Kentucky provides support to individuals in a variety of ways including:

- Three regions have an Assertive Community Treatment Team;
- Three regions have mobile outreach teams;
- Two regions provide specialized intensive case management for forensic clients and;
- Six regions provide continuity of care case management for special populations.

During SFY 2006, efforts will continue to involve stakeholders in identifying key components essential to an Assertive Community Treatment (ACT) model particular to Kentucky, as well as to explore potential funding mechanisms. Additionally, Department staff will continue to provide technical assistance to existing, modified ACT programs operating in the state. Efforts will also continue to develop partnerships and collaborate with state colleges and universities in developing and

incorporating case management training and curriculum into routine class work for students training to provide mental health services.

State Perspective
KDMHMRS supports case management through the Regional Boards in a variety of ways:

- The Division of Mental Health & Substance Abuse, designates a statewide coordinator of case management services;
- KDMHMRS requires and provides certification training for all case managers within six months of employment;
- KDMHMRS, in collaboration with the Kentucky Department of Education Division of Exceptional Children Services, the State Interagency Council for Services to Children with an Emotional Disability, the Kentucky Center for School Safety, the Office of Family Resource and Youth Services Centers, and the Department of Juvenile Justice conducts a continuing education conference that is specific to developing best practices in case management for a broad range of populations and needs;
- KDMHMRS funds demonstration projects for the provision of case management services of a more intensive design to persons with severe mental illness who have a history of violent or volatile behavior;
- Evidence-based practices such as Assertive Community Treatment are in varying stages of implementation as pilot projects in a few regions in the state and are being studied for possible expansion and implementation in other regions; and
- KDMHMRS has established a case management partnership including representatives from mental health, mental retardation, substance abuse, brain injury services, and the Department for Medicaid Services. This partnership, called the case management work group, has developed a common definition, principles and practice guidelines. This group is exploring commonalties for training and service quality improvement.

Rehabilitation Services

Regional Perspective
A review of the information from the SFY 2006 regional plan applications reveals that access to rehabilitation services are available in all 120 of Kentucky's counties.

- All fourteen regions provide access to Therapeutic Rehabilitation Program services with 85 programs available throughout the state;
- Six regions provide access to long term supports through supported employment services for adults with severe mental illness;
- Five regions have specifically adopted the psychiatric rehabilitation model to direct their rehabilitation services; and
- All fourteen regions provide access to educational support through community support program services.

Although adult rehabilitation services are available to individuals in all 120 counties in the state, access to services is inconsistent and often inadequate to meet the need. The federal estimate of 2.6% of the adult population as having a severe and persistent mental illness identifies about 89,000 adults in Kentucky as meeting this criterion.
The majority of adults with severe mental illness in the state do not participate in rehabilitation services offered through the Regional Boards. In SFY 2004, only 4205 adults with severe mental illness participated in a Therapeutic Rehabilitation Program. National estimates report that approximately 43% of adults with a psychiatric disability are employed full or part time yet statistics for Kentucky indicate that only 10% of people with psychiatric disabilities are employed.

The delivery of quality, timely rehabilitation services is challenged by a number of factors including:

- The current billing system that limits therapeutic rehabilitation as a site based service limiting community skills taught in the natural community;
- Kentucky Medicaid rates for therapeutic rehabilitation are quite low and significantly below the reimbursement rate for outpatient treatment services;
- Therapeutic Rehabilitation Program services are inconsistent and have not adopted a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a severe mental illness; and
- Supported education is not reimbursed by Medicaid and is actually interpreted by some centers as being discouraged due to the possible interpretation of duplicity of services.

State Perspective

KDMHMRS incorporates the philosophy of "psycho-social rehabilitation" (outcomes improve when skills are taught in a social setting) and **"**recovery**"** (outcomes and satisfaction improve when consumers develop new meaning and purpose in life and grow beyond the catastrophic effects of mental illness) to assist the development of Community Support Services. As psychiatric rehabilitation technology has evolved, KDMHMRS has promoted rehabilitation and recovery models through training, education, technical assistance, and targeted funding opportunities.

KDMHMRS promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two decades. This model also addresses the four major components of Community Support Services identified by KDMHMRS with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

Currently KDMHMRS, Kentucky Medicaid, the Regional Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted various models but, without system support, have had difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

KDMHMRS supports the provision of three key rehabilitative services at the regional level: therapeutic rehabilitation, supported employment, and supported education. While they each rely on psychiatric rehabilitation technology, they are supported in very different ways.

KDMHMRS supports rehabilitation services through the Regional Boards in a variety of ways:

- The Division of Mental Health and Substance Abuse designates a statewide community support program coordinator;
- KDMHMRS offers technical assistance and training for Community Support Program Directors who coordinate services for the state's eighty-five (85) **therapeutic rehabilitation programs** (TRP). **Therapeutic rehabilitation programs** are goal directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming;

- KDMHMRS has an interagency agreement with the Department for Vocational Rehabilitation that uses CMHS Block Grant funds to leverage **supported employment** services for adults with severe mental illness. In SFY 2004, 1642 individuals in the state were served with supported employment;
- KDMHMRS worked collaboratively in SFY 2004 and SFY 2005 with the Kentucky Business Leadership Network to increase employment opportunities for adults with severe mental illness through planning and participating in business forums that promote community awareness and education and the implementation of a job placement website for adults with disabilities;
- KDMHMRS worked collaboratively in SFY 2004 and 05 with the Office of Vocational Rehabilitation and the Interdisciplinary Human Development Institute at the University of Kentucky to develop a Supported Employment Training for providers of mental health rehabilitation services in Kentucky which was offered quarterly in various geographic locations throughout the state;
- Improving access to **educational services** through sites that provide Community Support Services was a new priority for SFY 2005. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills necessary to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with a serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services has been a priority for Community Support Program Directors in community mental health settings.

Housing Options

Regional Perspective

During SFY 2006, KDMHMRS, Kentucky Housing Corporation (KHC) and the Kentucky Association of Regional Programs will continue collaborating on the development of a Statewide Housing Project involving low-income housing tax credits. This project involves the construction of twelve new units of scattered site affordable rental housing in a number of rural counties. Regional Boards will serve as local project sponsors and be responsible for site selection, construction, tenant selection, property management and service provision.

Regional Boards use a variety of strategies to develop housing options for individuals with severe mental illnesses. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs or through collaborative arrangements with local public housing agencies. A review of the information from the SFY 2006 regional plan applications reveals that:

- There are currently 466 units/beds in 43 projects operated by the Regional Boards;
- All regions operate housing projects that provide residential support;
- Six regions operate a Tenant Based Rental Assistance program;
- Nine regions have organized formal supported housing programs;
- Ten regions report having developed a regional housing plan; and
- Thirteen regions provide specialized housing training to agency staff.

State Perspective

KDMHMRS began funding a full-time Statewide Housing Coordinator in 1993 to work with consumers, Regional Boards, and the Kentucky Housing Corporation (KHC) to develop housing options. The Housing Coordinator supports local efforts through:

- Technical assistance with housing support specialists and local housing developers;
- Supportive housing meetings;
- Special training events; and
- Collaboration with the Kentucky Housing Corporation, the Council on Homeless Policy, the Housing and Homeless Coalition of Kentucky, and other key state housing organizations.

Additionally, KDMHMRS collaborates with KHC in two key initiatives:

- The Supportive Housing Specialist position, which is jointly funded by the KHC and KDMHMRS, works to further integrate the housing needs of persons with mental illness into the state housing finance agency's programs. Technical assistance and consultation in developing housing projects is provided to local nonprofits by the Specialist.
- KDMHMRS provides $400,000 in annual funding to KHC to create a "set-aside" account within KHC's Affordable Housing Trust Fund (AHTF). The AHTF was established in 1996 to spur development of new housing projects for individuals with mental health, mental retardation or developmental disabilities, or substance abuse problems. Through December 2004, approximately 63 projects housing the Department's priority populations have been developed. These projects have provided 613 units in a mix of permanent and transitional housing settings.

Although the Regional Boards have developed housing options for their clients, this can never be the central mission of the organization. More partnerships are needed with local public housing agencies, non-profit and for profit housing developers, and other housing and service agencies. The Regional Planning Councils for the HB 843 Commission, non-profit developers and housing advocates have identified the following needs and barriers to housing.

- Consumers need increased availability of affordable housing options throughout the state;
- There needs to be more direct state funding and federal matching monies for housing options that include independent living, transitional housing, halfway houses, group homes, assisted living, supervised apartments and sober housing for individuals in recovery;
- Collaboration should take place with the Kentucky Housing Corporation and other agencies to finance housing developments for consumers;
- There should be increased state funding for housing supports and increased housing options for persons being discharged from state institutions or at risk of institutionalization;
- There is insufficient funding for housing related support services;
- In the rural areas, there is a lack of appropriate housing and nonprofit developers;
- Many persons with a mental illness have experienced legal, financial and eviction problems which exclude them from housing programs;
- Stigma of mental illness remains a problem, excluding persons from some homeless shelters and housing services;
- Waiting lists for Section 8 vouchers are closed or extremely long in most parts of Kentucky.

Performance Indicators and Action Plans may be found at the end of this Criterion

Physical Health System

Regional Perspective

Regional Boards are required to assess the physical health of each consumer they serve. Clinicians and case managers work closely with parents, community primary care physicians, local health departments, other health care providers, and schools to address the overall health needs of adults. Physical health services are available through Medicaid or local "free" clinics that provide indigent health care. A number of regional MHMR Boards have chosen to "partner" with local health providers in developing/constructing clinics with shared space for both mental and physical health. These partnerships have been very successful in better identifying both mental health and physical health problems experienced by members of their community.

State Perspective

The interface of physical health and mental health is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in

the physical healthcare arena. Continuity of care across these systems is critical if individuals are going to recover and succeed in establishing chosen roles in the community.

To help focus on improving access to dental and physical health services, a representative of the Department for Public Health was recommended as a member of the Kentucky Mental Health Services Planning Council. That representative has been attending planning council meetings since SFY 03 and contributing valuable suggestions for collaboration between the physical health and mental health system.

Criminal Justice System

Regional Perspective
Regional Boards provide training to a number of entities in the criminal justice system in order to assure persons with severe mental illness are diverted into treatment whenever possible rather than arrested and booked into jail. In Jefferson County the Crisis Intervention Team has been in place for over 3 years and has successfully diverted thousands of individuals into care.

The relationship between Regional Boards and local jails has been enhanced through the delivery of the mental health and suicide prevention training that the Boards have been providing. Funding was also included to provide consultation to the jails, on an as needed basis, to improve jail personnel's response in dealing with inmates with behavioral health needs. Regional Boards reported entering into more formal agreements with their local jails in thirty-one counties across the Commonwealths in FY 2004.

HB 157 was successfully implemented across the state during SFY 2005, which mandated KDMHMRS develop a statewide crisis triage system for local jails to access a qualified mental health professional to complete an assessment of individuals who were at risk of suicide or behavioral health issues. Regional boards received training in conjunction with their local jails regarding the process for utilizing the system and their roles in regards to the management of risk.

State Perspective
Since the implementation of a multi-faceted legislative initiative in 1994, Kentucky has eliminated the use of jails during acute psychiatric crises and the involuntary hospitalization process. Instead, consumers are evaluated in emergency rooms or by staff of Regional Boards. These efforts have:

- Increased understanding of mental illness by emergency responders such as ambulance drivers, paramedics, and peace officers;
- Improved access to evaluation and treatment;
- Improved communication among local peace officers, judges, mental health professionals, other community resources and the general public; and
- Reduced the stigma and trauma of involuntary hospitalization.

KDMHMRS has intensified efforts to build an integrated service system for individuals with serious and persistent mental illness who are involved in the criminal justice system. The need for collaboration among KDMHSA, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net" to serve persons with mental illness has become an increasingly apparent.

In SFY 02, as the result of a series of investigative reports published in the Louisville Courier Journal related to suicides in local jails, the legislature appropriated $550,000 to KDMHMRS to develop a training curriculum for jail staff to address this issue. During SFY 03, KDMHMRS developed, implemented and monitored this training curriculum on suicide prevention and recognizing the signs and symptoms of mental illness. Regional board staff were trained in a "model curriculum" and then expected to train the staff in their local jails. In addition to this training, Regional Boards were

encouraged to improve their working relationships with the local jails to assure mental health needs were being met for inmates housed in these facilities.

During SFY 2005, KDMHMRS implemented a new project in local jails that established a behavioral health telephonic triage system. Funding was allocated in the 2004 legislative session to establish this system as well as fund the follow-up services that may be indicated. The system includes the availability of a qualified mental health professional 24 hours a day, 7 days a week by telephone, to assess and make recommendations for housing, classification and treatment for individuals booked into jail who may have a mental illness, mental retardation, brain injury or be at risk of suicide. In the case where it is indicated that a person needs to be seen face to face by a mental health professional, response times were built into the system based upon the level of risk assigned.

KDMHMRS will continue to utilize block grant funds to partner with NAMI Kentucky to fund a cross-systems training coordinator during SFY 2006 This position will continue to work across multiple systems (including mental health, mental retardation, substance abuse, corrections, criminal justice training, jailers association, and Kentucky State Police) to advocate for and coordinate training modules for first responders that encounter persons with behavioral health disabilities.

Persons Who are Aging

Regional Perspective
A review of regional SMI plans indicate that Regional Boards are very much involved in activities related to the elderly, have mental health and aging coalitions and provide services to older adults. Activities at the regional level have increased. Approximately thirteen (13) regions report that they have and provide support to a local mental and aging coalition. A majority of the support provided is a designated staff person to attend and participate in coalition activities. One region is involved with a Grandparent Support Group. Regions also provide material for training, sponsor training or have facilities available for meetings and training. Staff also present at coalition conferences.

A summary of types of services provided by the Regional MHMR Boards include:
- One Regional Board provides Adult Day Health Care services in their entire region;
- Six (6) regions provide In Home Services;
- Twelve (12) Regional Boards provide mental health services in nursing facilities and personal care homes.

Other services include: referral to private providers, public education regarding depression in the elderly, mental health and aging training conference, Caregiver support services, Elder Care Task Force, and education services on issues related to elderly and mental health. Five (5) Regional Boards report that they have a designated staff person/unit responsible for providing mental health services to older persons. Eight (8) Regions have older persons as representatives on the Regional Board of Directors**.**

State Perspective
In Kentucky, the elderly (over 60) population represents fourteen percent of adults with a severe mental illness who are served by Regional Boards. In order to promote education, public awareness, and to improve services to the elderly, KDMHMRS has initiated a State Perspective mental health and aging coalition which was established in October of 1999. This coalition remains active and meets on a quarterly basis. The State Perspective coalition, the Kentucky Mental Health and Aging Coalition, has provided funding to local regional coalitions in order to promote education, needs assessment, resource development and public awareness at the Local Perspective.

The KDMHMRS also provides training opportunities through the Mental Health Institute, PASRR Training and Case Management conference on an annual basis. Scholarships are offered to facilitate attendance at the Annual Summer Series on Aging Conference. In conjunction with UK OVAR GEC, the Department provides an annual statewide training to certified PASRR evaluators.

KDMHMRS has established partnerships with other agencies whose mission is to provide services and training for the elderly through serving on boards, task forces and Committees. The groups include but are not limited to: the Summer Series on Aging Planning Board, through the UK Sanders Brown Institute, Aging Work Group for House Bill 843, Alzheimer's disease and related Disorders Council, and Kentucky KinCare Statewide Steering Committee.

The barriers as identified by the HB 843 Older Adults Work Group are a lack of interface between physical and behavior health care, transportation, provision of services in a variety of venues (in-home, clinic site, nutrition site, senior center etc.) due to physical and medical disabilities, and lack of adequate funding for service to the older adult population.

The KDMHMRS priorities would be to continue to sponsor the Kentucky Mental Health and Aging Coalition and the HB 843 Aging Work Group in order to continue to encourage the development of public awareness, training, education and coordination of services for older adults at the state and the Local Perspective.

Services to Persons who are Deaf and Hard of Hearing

Regional Perspective

State Perspective

KDMHMRS employs a Statewide Coordinator for services to the deaf or hard of hearing. This position, in place since 1994, oversees all efforts to improve services for this population. In September 2002, a Program Coordinator was hired to work closely with the Statewide Coordinator. In response to the special accessibility problems of consumers who are deaf or hard of hearing, an Advisory Committee for Mental Health Services for the Deaf and Hard of Hearing was established by KRS 210.031 in 1992. Meeting on a quarterly basis and supported by these staff members, the advisory committee implements and monitors a variety of statewide and local consumer initiatives. Currently, there are 4 Masters level therapists fluent in sign language serving in 4 regions throughout the state and 1 case manager fluent in sign language in the Danville area.

The challenge to KDMHMRS to improve services to persons who are deaf or hard of hearing is contained in a report, "New Directions for Mental Health and Deafness," prepared in June 1998 by consultants to the Advisory Committee and KDMHMRS. The report estimates that approximately 200 adults with severe mental illness, and 90 children with severe emotional disabilities, are deaf and will seek mental health services during a year. The recommendations from this report are listed in the GAP Analysis.

The Department, the Regional Boards, and the Legislature are responding to the challenge of the report. TTY devices have been installed in critical service sites throughout the state, including community mental health centers, state facilities and toll-free crisis lines. Individuals who are knowledgeable in deafness and mental health issues staff a statewide TTY Crisis Line. In addition to the providers, KDMHMRS staff has also received training in their use and in deaf awareness. Limited funds have been made available for interpreters, training and equipment to make local treatment more accessible. Interpreters are routinely available to facilitate the participation of consumers who are deaf or hard of hearing in meetings and conferences.

Kentucky Guidelines for Services for Deaf and Hard of Hearing, Late Deafened, and Deaf Blind People has been disseminated to all fourteen Regional Boards; Rape Crisis Centers, domestic violence staff and substance abuse staff. The Guidelines have been revised and retitled "Kentucky Standards of Care for Deaf and Hard of Hearing, Late Deafened and Deaf Blind People". The revised Standards of Care will be disseminated to all mental health service providers.

The Kentucky Deaf Access Consortium (KDAC) is a partnership between Eastern Kentucky University (EKU), the Office of Vocational Rehabilitation (OVR), KDMHMRS and the Kentucky Commission on the Deaf and Hard of Hearing (KCDHH). It is a consortium to support the four partners in expanding their capacities to serve the deaf and hard of hearing community with remote interpreting via videoconferencing. This consortium, through EKU, received a three-year federal grant in October of 2001.

Services to Persons with Brain Injuries

Regional Perspective
There are currently twenty-five active providers enrolled in the Acquired Brain Injury Medicaid Waiver program. Residential service providers are located in Ashland, Lexington, Louisville, Owensboro, and Paducah. While services are available in the most populous regions of the state, persons in rural communities often have difficulty obtaining the services of an enrolled provider.

Case management services are available statewide under the Traumatic Brain Injury Trust Fund program. Thus, access to financial assistance and case management services are available to eligible persons throughout the Commonwealth.

State Perspective
In 1999, Kentucky initiated two programs serving persons with acquired brain injuries: the Traumatic Brain Injury Trust Fund; and the Acquired Brain Injury Medicaid Waiver program. Today these programs serve a combined total of approximately 1,800 children and adults – less than 1% of those who may be in need of services to overcome the effects of a brain injury.

There are currently two dedicated resources for children and adults with brain injuries in Kentucky: the Acquired Brain Injury Medicaid Waiver Program; and the Traumatic Brain Injury Trust Fund Program. The Acquired Brain Injury Medicaid Waiver Program can serve 110 adults aged 21 to 65 years who meet nursing facility level of care, are financially eligible for Medicaid services, and who show the potential to progress. This intensive rehabilitation program offers fourteen services including case management, day program, supported employment, occupational therapy, speech and language therapy, counseling, behavior programming, companion services, personal care, residential, specialized equipment, environmental modifications, and respite care. The program is not intended to provide long-term care and its emphasis is on improving or restoring an individual's functioning. This program now has a waiting list of over 50 persons.

The Traumatic Brain Injury Trust Fund Program is designed to fill the gaps in service delivery that many people with brain injuries experience. To be eligible, an individual must have a brain injury and must have no other payer source for the needed service or supports, including wrap around services. Case management is provided to all recipients. Benefits to recipients are limited to $15,000 annually and $60,000 per lifetime. The cost of case management services is not deducted from the person's annual or lifetime caps. This program can serve approximately 1500 persons annually and now has a waiting list of over 600 children and adults.

Performance Indicator 1

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase access to targeted case management provided by Regional Boards by at least .2% above number served in 2004.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Penetration Rate- Adults with SMI Receiving Targeted Case Management

Value:	Percent
Numerator:	Number of adults with SMI served by Regional Boards who received a Targeted Case Management service.
Denominator:	2.6 percent of the Kentucky adult census.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SMI marker in the MIS.

Performance Indicator 2

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Decrease readmissions of adults with SMI, who had been discharged from the same facility with 30 days preceding, from 16% to 14.5 %.
Population: Adults with SMI
Criterion: 1
Performance Indicator: State Hospital Readmission for Adults with Severe Mental Illness / 30 Days

Value:	Percent
Numerator:	Number of admission episodes during the reporting period in which adults with SMI had been discharged from the same facility with 30 days preceding admission.
Denominator:	Total number of admissions of adults with SMI to the facility that occurred in the state fiscal year.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SMI marker in the MIS.

Performance Indicator 3

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Decrease readmissions of adults with SMI, who had been discharged from the same facility with 180 days preceding, from 50% projected in 2005 to 40%.
Population: Adults with SMI
Criterion: 1
Performance Indicator: State Hospital Readmission of Adults with Severe Mental Illness / 180 Days

Value:	Percent
Numerator:	Number of admission episodes during the reporting period in which adults with SMI had been discharged from the same facility with 180 days preceding admission.
Denominator:	Total number of admissions of adults with the SMI marker to the facility that occurred during the reporting period.

Sources of Information: MIS is the source for actual number served by state hospitals. Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the increase in demand for services due to closure of most private psychiatric beds for adults across the state. This indicator has been refined to Adults with Severe Mental Illness (instead of all clients). Further analyses of the data are planned to determine the number of individuals this high percentage of readmissions represents.

Performance Indicator 4

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase percentage of outpatient appointment within 7, 14 and 30 days after discharge 46%, 70%, and 78% respectively.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Continuity of Care--Outpatient Care

Value:	Percent
Numerator:	Total number of state hospital discharges of adults with SMI in which the adult was seen for an outpatient appointment within 7, 14, and 30 days after discharge.
Denominator:	Total number of state hospital discharges of adults with SMI.

Sources of Information: MIS is the source for actual number served by state hospital admissions and outpatient appointments. Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served. Assurance of a seamless system of care for this population that includes timely, easy access to aftercare from hospitalization is a priority. Ideally, all persons with SMI would be seen within fourteen days of discharge. This indicator allows for more detailed data regarding timeliness of aftercare appointments.

Performance Indicator 5

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.

Target: Increase percentage of adults with SMI who are employed full time from 12.7% in 2004 to 13.5% in 2006.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percentage of Adults with SMI Receiving Services Who are Employed

Value:	Percent
Numerator:	Number of adults with SMI served by Regional Boards who have an employment status of "employed full time" (32 hours or more per week), "employed part time" (less than 32 hours per week) , or "in armed forces."
Denominator:	Number of adults with SMI served by the Regional Boards.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served as a key goal for all individuals is meaningful activity during the day including employment.

Performance Indicator 6

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase percentage of adults with SMI who live independently from 68% in 2004 to 69% in 2006.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percentage of Adults with SMI Receiving Services Who Live Independently

Value:	Percent
Numerator:	Number of adults with SMI served by Regional Boards who are living independently.
Denominator:	Number of adults with SMI served by the Regional Boards.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served as a key goal for all individuals is to live in preferred residential setting, which often means independently.

Performance Indicator 7

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: The percentage of adults with SMI involved with the justice system and who are in need of mental health services accessing services from the Regional Boards is anticipated at 5.2%.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percent of Adults with SMI Receiving Services Who Have Contact with the Justice System

Value:	Percent
Numerator:	Number of adults with severe mental illness (SMI) served by Regional Boards who have a primary or secondary source of referral of justice system.
Denominator:	Number of adults with severe mental illness (SMI) served by Regional Boards.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of programming at the Regional Boards.
Significance: An overarching goal of the Department is to ensure that all individuals, in need of mental health services, who are involved with the justice system receive needed services.

Performance Indicator 8A

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase the percentage of available evidence-based practices available to adults with SMI served by the Regional Boards.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Evidence-Based Practices Provided by Regional Boards including: Supported Housing (SH); Supported Employment (SE); Assertive Community Treatment (ACT); Integrated Treatment for Mental Health and Substance Abuse (IT); Illness Management and Recovery (IMR); and Family Psychoeducation (FPEd).

Value:	Percent
Numerator:	Number of Regional Boards providing each EBP for adults with SMI.

Sources of Information: Department staff derives this data from and create targets based upon the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of programming at the Regional Boards.
Significance: All individuals seeking services at Regional Boards have a right to have evidence-based practices available to them. This data has not historically been collected to allow for comparison/trend data.

Performance Indicator 8B

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase the percentage of evidence-based practices available to adults with SMI from the Regional Boards.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percent of Adults with SMI Receiving Services Who Receive Evidence-Based Practices

Value:	Percent
Numerator:	Number of adults with severe mental illness (SMI) served by Regional Boards who received each EBP.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: All individuals seeking services at Regional Boards have a right to have evidence-based practices available to them. This data has not historically been collected to allow for comparison/trend data.

Performance Indicator 9
Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase the percentage of adults with SMI who receive evidence-based practices from the Regional Boards.
Population: Adults with SMI
Criterion: 1
Performance Indicator: SMI Adult Consumer Perception of Care

Value:	Percent
Numerator:	Percent of adults with severe mental illness (SMI) reporting positively about treatment outcomes.
Denominator:	Total number of responses from adults with SMI on the consumer satisfaction instrument.

Sources of Information: Historical data is limited to a study of consumer satisfaction with services for conducted in 2000. Future collection of this indicator is to be determined within this fiscal year. It is anticipated that the information will be collected from the Regional Boards using a standardized tool.
Significance: The perception of care as reported by consumers of services is a valuable piece of data to ensure that services are meeting the needs of those served.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

STATE ACTIONS PLANS

CRITERION 1

Component 1: Consumer and Family Support

The emphasis on recovery is recognized as a priority, and statewide initiatives will focus on issues that directly impact the lives of stakeholders. Initiatives in SFY 2006 will include:

- Strengthening the education of consumers and family members about mental illness;
- Providing consumer wellness and recovery programs;
- Preparing consumers for responsible involvement in meaningful health planning at the state and regional levels;
- The development of consumer leadership within local communities;
- Identifying strategies and coordinating activities that involve mental health consumers and family members in state and regional planning and programs;
- Working collaboratively with NAMI KY and KY CAN on the consultative peer review process and training;
- Working collaboratively with NAMI KY and KY CAN to provide access and availability to technology for consumer and family members;
- Developing a brochure about grievance procedures;
- Improving access to "Ticket to Work" and other employment initiatives; and

- Maintaining communication with consumer and family advocates.

    - **State Objective A-1-1:** Support the Peer Review process coordinated by KY CAN

Component 2: Emergency Services

Emergency Services
KDMHMRS is committed to assuring that each Regional Board serves as the "safety net" for persons with mental illness who may be in crisis. The foundation for the establishment of a responsive, effective, and efficient crisis response system of care is currently built upon the 24-hour crisis telephone services and the availability of qualified mental health professionals to screen persons for involuntary psychiatric hospitalization.

A flexible array of crisis services is needed in each region in order to meet the diverse needs that consumers in crisis may be experiencing. For this reason, KDMHMRS is very interested in outcomes related to the recent development of a more flexible crisis stabilization service in one region of the state. This region created a " flexible crisis stabilization program" by utilizing their allocation for a crisis stabilization unit to fund four crisis case managers (who are available 24 hours a day, 7 days a week), as well as to purchase crisis beds in various locations in their region.

Some Specific Needs Identified include:
- Additional crisis case management staff;
- Assertive community treatment;
- Additional mental health professional to evaluate individuals seeking voluntary; hospitalization after hours
- Additional crisis stabilization beds;
- Additional training for first responders;
- Additional funding would be needed to assure a full array of crisis services in each region.

Currently KDMHMRS is re-evaluating the role of crisis stabilization units in each region. Kentucky is experiencing a reduction in private psychiatric bed availability, in addition to a reduction in funding for our state operated and state contracted hospitals. As the number of inpatient psychiatric beds continues to be reduced, the role of crisis stabilization units becomes even more critical to meeting the needs of persons with mental illness who may be experiencing a crisis.

- **State Objective A-1-2:** Assist Regional Boards in implementing and monitoring crisis stabilization programs thorough statewide technical assistance meetings.
- **State Objective A-1-3:** Assist Regional Boards and local jails in the development, implementation and monitoring of behavioral health jail telephonic triage system.

Component 3: Mental Health Treatment

Continuity of Care/ Reduction in Inpatient Psychiatric Care
Assurance of a seamless system of care for consumers is a high priority for KDMHMRS. Fragmentation of service delivery can have widespread impact on the quality of consumers lives, as well as an increased readmission rate to inpatient facilities, contact with the criminal justice system, a reduction in level of functioning, and a whole host of other ramifications. A need for strong collaboration among KDMHMRS, the state hospitals and local community mental health centers is needed to assure that individuals do not 'fall through the cracks" of the system.

KDMHMRS uses a number of strategies designed to improve continuity of care including:

- Participating in continuity of care meetings convened by the four state hospitals;
- Producing a quarterly continuity of care report showing data trends; and
- Focusing on continuity of care issues in state hospital and Regional Board monitoring.

❖ **State Objective A-1-4**: Assure and monitor the development of Memorandums of Agreement between state operated/state contracted hospitals and Regional Boards.

Outpatient Services

In addition to providing funding, KDMHMRS and the Regional Boards use the following strategies to insure that integrated mental health treatment services are available as consistently as possible across Kentucky's fourteen mental health regions:

- Supporting the use of new assessment software applications such as LOCUS to insure consistent assessment of levels of care;
- Promoting the use of evidence-based treatment guidelines such as medication algorithms and dialectical behavior therapy;
- Recruiting of Advanced Registered Nurse Practitioners (ARNPs) who can prescribe medications in association with a psychiatrist;
- Establishing standards for ensuring continuity of care across treatment settings.
- Mandatory training for all adult service case managers and their supervisors includes a two-hour training session on co-occurring disorders;
- The Kentucky School for Alcohol and Drug Studies and the Mental Health Institute provide training on co-occurring disorders for consumers, family members and providers.

❖ **State Objective A-1-5:** To promote integrated treatment for persons with co-occurring disorders, provide at least one statewide training opportunity on Motivational Interviewing techniques.

Component 4: Specialized Mental Health Treatment

Case Management

Although adult case management services are available in all 120 counties in the state, access to services is inconsistent and sometimes inadequate to meet the need. The statewide average in SFY 2004 for access to targeted adult mental health case management was 7.8%, ranging from 3.8% in one region to 32% in another.

The delivery of quality, timely case management services is challenged by a number of factors including:

- The current billing system considers four contacts per month a unit of service. Contacts above or below this figure are not reimbursed;
- Kentucky Medicaid rates for case management were capped during SFY 03 and continued to be capped in SFY 2004 (due to deficits in the overall state Medicaid program); and
- Turnover among case managers is high; in general case managers have less status than outpatient clinicians and this "service" is often viewed as an entry level position.

KDMHMRS will use the following strategies to improve case management services

- Provision of initial and ongoing technical assistance and consultation to case managers and their supervisors;
- Coordination of an adult mental health case management advisory faculty to assist with case management training and curriculum development;

- Sponsorship of advanced training opportunities such as the annual Case Management Level II training; and
- Participation in the statewide case management work group to explore opportunities for developing and implementing new training technology;
- Promotion of evidence-based or "best" practices (such as Assertive Community Treatment).

    - ❖ **State Objective A-1-6:** Develop a pilot project for web-based Case Management Training by June 30, 2006.

    - ❖ **State Objective A-1-7:** Develop Case Management Standards of Care in collaboration with DMHMRS, DMS, Regional Boards, consumers, and family members.

Rehabilitation Services

Identified priorities include:

- Dissemination of information about evidenced based practices including psychiatric rehabilitation and supported employment to community support program directors with stakeholder meetings established to support adoption of a consistent and effective statewide model;
- Access to effective rehabilitation and supported employment training and supervision including best practices technology in community support program director meetings and the annual mental health institute;
- Planning and participation in regulatory changes regarding the community mental health center regulation;
- Utilizing data from the Multnomah Community Ability Scale (MCAS) for program evaluation to be distributed to the CSP directors.

Strategies include:

- Provision of initial and ongoing technical assistance and consultation to regional CSP directors and TRP directors;
- Planning and coordination of the quarterly community support program directors meeting to include best practice information, support, and collaboration;
- Partnership with advanced training opportunities such as the annual mental health institute training;
- Coordination and implementation of a Kentucky Recovery Initiative to transform our rehabilitation service system to a recovery oriented system of care through a time-framed plan with stakeholder participation;
- Promotion of evidence-based or "best" practices (such as supported employment, psychiatric rehabilitation, and integrated treatment);
- An additional strategy that has been very successful is the sponsorship of regional staff in securing their International Association of Psychosocial Rehabilitation Services (IAPSRS) credentials. In SFY 03, 30 regional staff and 18 in SFY 2004 availed themselves of the opportunity to take the IAPSRS test. It has been a goal of the DMH to increase the number of certified rehabilitation staff at the local level.

    - ❖ **State Objective A-1-8:** Implement the Multnomah Community Ability Scale functional assessment tool for all adults identified as SMI within the Regional Board treatment system in SFY 2006.

Housing

The Department embraces a "Supported Housing" approach to providing housing options for adults with severe mental illnesses. Supported Housing involves the linking of affordable, permanent, community-based housing options with flexible services and supports. It also assumes that individuals have preferences and should be involved in choosing where and with whom they live. CMHS Block

Grant funds have been critically important to the development of affordable housing while promoting linkages with housing related supports such as skills training, assistance in securing subsidies, and housing search activities.

KDMHMRS strategies to increase the percentage of consumers who live independently include:
- Establishing an email newsletter to disseminate housing information to statewide contacts;
- Promoting rental assistance program development;
- Providing training events on supportive housing and the subsidized housing delivery system;
- Participating in HB 843 and Olmstead planning activities;
- Providing technical assistance to local nonprofit housing developers through referral to KHC's Supportive Housing Specialist.

❖ **State Objective A-1-9:** Support the development of additional supportive housing units in the state by collaborating with the Kentucky Housing Corporation, the Housing and Homeless Coalition in Kentucky, the Council on Homeless Policy, and other key state housing organizations in the two-year Corporation for Supportive Housing initiative.

Physical Health System

While Medicaid provides a significant benefit for physical health care for many individuals with severe mental illness, many still do not have access to care. Individuals still visit hospital emergency rooms for routine physical health care. Other challenges include:
- Inability to afford costly physical health medications;
- Lack of follow-up by consumers with prescribed health regimens for chronic conditions (e.g. diabetes, heart disease);
- Limited formal agreements between primary care settings and Regional Boards; and
- Few examples of physical health and mental health service integration.

KDMHMRS encourages the use of formal or informal agreements between Regional Boards and local primary health care providers. It also monitors for the quality of care provided in assessing and arranging for the treatment of physical health conditions among individuals with mental illnesses. Ultimately, the development of performance indicators is necessary to insure that a consistent level of attention to physical health care needs is provided.

❖ **State Objective A-1-10:** Identify a methodology to assess the strength of the partnership between regional boards and their local health department.

Criminal Justice System

Ideally a full array of diversion and reentry programs would be available in communities to effectively serve adults with mental illness who interface with the Criminal Justice System. Specialized training for law enforcement utilizing the Crisis Intervention Team model, Mental Health Courts and reintegration planning are vital components in the development of interventions to reduce the likelihood of a person with severe mental illness cycling between the two systems.

Effective diversion and reintegration programs do put an increased burden on local providers since persons with severe mental illness are diverted into the mental health system rather than continuing to move into the criminal justice system. In times when resources are limited, many boards have struggled with finding effective ways to serve this challenging population.

The lack of a clearly identified funding source for jail based mental health care has been a long-standing barrier in the Commonwealth. Existing statutes conflict. One stipulates that the local jail is responsible for the payment of mental health care; another states that the Commonwealth is

responsible for the payment of this service. The passage of HB 157 and the establishment of the telephonic crisis network for local jails will improve communities' ability to identify and to treat individuals with severe mental illness who interface with the criminal justice system.

- ❖ **State Objective A-1-11:** Design and implement a sustained training program for Regional Board staff and their criminal justice collaborators on the interface of the behavioral health system and the criminal justice system.

Persons who are Aging

To continue to promote public awareness and education of the mental health needs of older adult the following objective was chosen.

- ❖ **State Objective A-1-12:** Fund at least 2 local coalitions to provide public awareness and education activities.

Persons who are Deaf and Hard of Hearing

Existing Barriers/Challenges to service delivery to this population includes:

- Funding sources
- Qualified staff proficient in sign language
- Culturally appropriate mental health services

KDMHMRS has identified the following areas for future development

- Establish residential treatment program for deaf children;
- Inpatient mental health units for adults and children who are deaf and experiencing acute mental illness;
- Psychiatric/substance abuse inpatient treatment program;
- Hiring a case manager, interpreter and Masters Level therapist as a "team" concept for each quarter of the state;
- Manage mental health interpreting services under a single statewide contract that is coordinated by the state mental health agency;
- Accessible housing for people who are deaf and have a mental illness
- Deaf therapeutic foster homes.

- ❖ **State Objective A-1-13:** Provide at least one in-service training related to serving the Deaf and Hard of Hearing population**.**

Persons with Brain Injuries

The Traumatic Brain Injury Trust Fund Board of Directors (the Board) initiated a strategic planning process by establishing a planning work group in February 2004. The planning group included stakeholders from across the brain injury community, including persons with brain injury, family members, service providers, and state agency personnel.

The Strategic Plan is designed to serve as a road map for the development of services and as a tool for responding to the continuously changing needs of citizens of the Commonwealth whose lives have been forever altered by an acquired brain injury. There are four broad goals in this strategic plan. The objectives under each goal are specific activities that will lead to the accomplishment of the goal. The plan outlines goals and objectives for a five-year period, and is an evolving document that the Board will review annually. The established goals are:

- **State Objective A-1-14:** Seek legislative action to require the helmets when riding bicycles, motor cycles, and ATV's, as well as legislation rendering the failure to use seat belts as a primary offense.

The Traumatic Brain Injury Trust Fund Board of Directors is now working with the Cabinet for Health and Family Services toward the adoption of the Strategic Plan as the template for the further development of services for persons with brain injury in the state.

Comments from Mental Health Planning Council meeting on August 18, 2005:

Comment: Make sure it is clearly stated that so many private psychiatric beds have closed.
Response: It is stated in a couple of places throughout but staff will review and make sure it is clearly stated.

Comment: Regarding Performance Indicator A 1-2a, State *Hospital Readmission Rate of Adults with SMI*, Council suggested changing 06 target from 13 to 14.5%.
Response: Staff agreed to change 06 target to 14.5%.

Comment: Medicaid has to provide funding for In-home services to adults with SMI if they truly want to lower hospital admissions. They need to fund, TR programs, additional outreach services need to be made available such as; home health, drop-in consumer services; and voluntary wrap around services in the community. Kentucky has a long way to go.
Response: Comments acknowledged.

Comment: Does Performance Indicator A1-6 Percents of Adults with SMI and receiving community mental health services who are living independently include personal care home residents?
Response: No, personal care home residents are not considered living independently. Staff discussed how data is collected.

Comment: Regarding A 1-9 the Emergency Preparedness Grant needs to be looked at in conjunction with Housing.
Response: Comment acknowledged, staff will follow through.

Criterion 2: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data

This plan describes how quantitative population targets are to be achieved through the implementation of the mental health system, including estimates of the numbers of individuals with severe mental illness in the state (or prevalence rates) and the numbers of such individuals served.

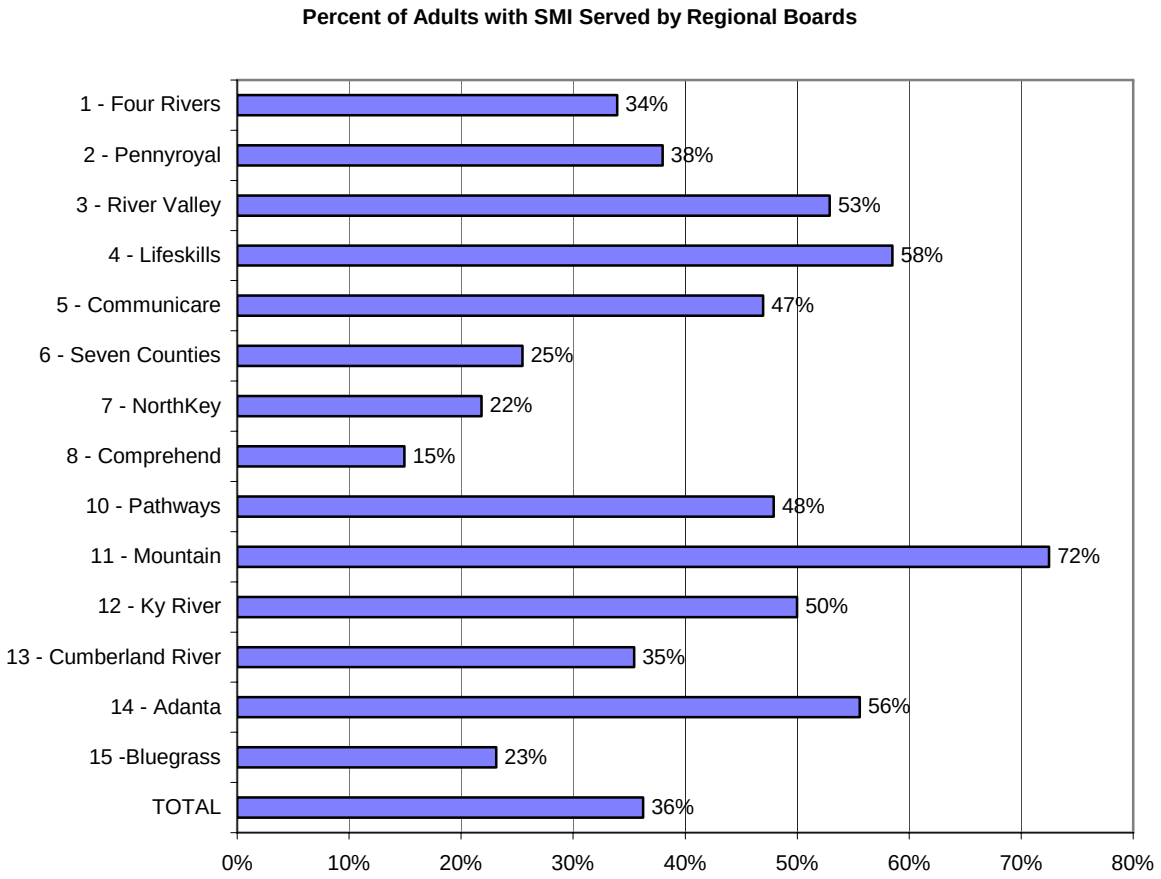
Goal: To increase access to services for adults with severe mental illness.

Component 1: SMI Prevalence

REGIONAL PERSPECTIVE

The following table uses the federal SMI prevalence rate and 2000 census data to estimate, by mental health region, the number of Kentucky adults with SMI using the federal definition. That estimate is compared to the number of unduplicated adult clients with severe mental illness served by the Regional Board during SFY 2005. A resulting regional penetration rate is calculated.

Regional Boards	Adult Census 2000	Federal SMI Estimation	Kentucky SMI Adults Served	Penetration Rate
Four Rivers	157,510	4,095	1,389	34%
Pennyroyal	154,361	4,013	1,524	38%
River Valley	155,001	4,030	2,132	53%
Lifeskills	193,083	5,020	2,936	58%
Communicare	177,804	4,623	2,171	47%
Seven Counties	654,224	17,010	4,335	25%
NorthKey	286,137	7,440	1,624	22%
Comprehend	41,452	1,078	161	15%
Pathways	162,796	4,233	2,027	48%
Mountain	121,476	3,158	2,289	72%
Kentucky River	91,201	2,371	1,185	50%
Cumberland River	177,872	4,625	1,639	35%
Adanta	147,152	3,826	2,127	56%
Bluegrass	526,882	13,699	3,169	23%
TOTAL	**3,046,951**	**79,221**	**28,708**	**36%**



STATE PERSPECTIVE

Kentucky's earliest estimates of the prevalence of severe mental illness were based on national work. In 1980, the U.S. Department of Health and Human Services (USDHHS) estimated that 3.14 percent of the population had some level of mental disorder, and that 0.75 percent of the population had a mental disorder that causes prolonged disability.

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for "adults with severe mental illness." CMHS was further required to develop an "estimation methodology" based on the definition that state mental health agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by the definition. The federal definition of "adults with a severe mental illness" was published on May 20, 1993.

Early planning in Kentucky for adults with severe mental illness, using the 0.75 prevalence rate for adults with persistent disability, estimated that approximately 28,000 adults in Kentucky should be the priority population for services. Kentucky's mental health planning has historically focused on this subset of the population in development of its Community Support Services plan.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of "chronic mental illness"; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with severe mental illness consistent with national policy.

Kentucky's definition of "adult with severe mental illness," as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration: Kentucky's definition is narrower than the definition promulgated in the federal register for "Adult with Severe and Persistent Mental Illness." Historically, stakeholders have supported the Department's desire to focus limited funding on adults who meet the state's narrower definition.

Variable	Criteria
Age	Age 18 or older
Diagnosis	Major Mental Illness • Schizophrenia (DSM 295.xx, 297.1, 298.9) • Mood Disorder (296.xx) • Other (DSM _____) within State and Federal Guidelines for Severe Mental Illness
Disability	Clear evidence of functional impairment in two or more of the following domains: • Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores. • Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings. • Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture. • Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries. • Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.
Duration	One or more of these conditions of duration: • Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years. • The individual has been hospitalized for mental illness more than once in the last two- (2) years. • There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time

The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with severe mental illness, and a rate of 2.6 percent for adults with severe and persistent mental illness (SMI).

Component 2: Mental Health Systems Data

REGIONAL PERSPECTIVE

At the local Regional Board level, outcome instruments are being used for program evaluation, identification of staff training needs, and client treatment planning. Consumers, Regional quality assurance staff, Community Support Program directors and Department staff have cooperated in the

development of useful reports from the outcomes data. These reports will soon become available on the Department's web site for their use.

STATE PERSPECTIVE

The Cabinet for Health and Family Services, as part of the Executive Branch strategies statewide, is moving toward performance-based contracting. Therefore, the Department continues planning with its primary contractors, the Regional Boards, to measure and manage organizational performance and clinical/personal outcomes. The Regional Boards remain essential partners with the Department, as well as with consumers, families, and advocates, in identifying what outcomes need measuring, what instruments are appropriate for measuring those outcomes, and what resources are required for implementing the measures. A significant amount of outcomes data collection occurs now as a result of that collaboration. The improvement of these data sets and the addition of new measures will complement what is already in place.

For over ten years, the Department has been building a system to structure and house data. Within this system, the Department continues to review and improve the quality of datasets collected monthly from Regional Boards and the state hospital facilities. These datasets include:

- Client, Event, and Human Resources data from Community Mental Health Centers;
- State hospital facility Admission and Discharge Data.

The Division of Mental Health has been addressing the issue of outcomes for the two main populations they serve: Adults and Children. The following addresses specific outcomes initiatives within the Adult Mental Health Services arena*:*

- *Brief Psychiatric Rating Scale (BPRS) for Crisis Stabilization Consumers* which is currently administered upon consumer admission and discharge of each Crisis Stabilization Unit
- *Multnomah Community Ability Scale and the Medical Outcomes Study Health Status Survey for SMI consumers* which is administered upon client admission and at consequent six-month intervals. Implementation of the use of the instrument will extend over a three-year period. The selected population will be consumers of Therapeutic Rehabilitation Services in the first year, will expand to include consumers of Case Management Services in the second year and expand to all remaining SMI consumers in the third year.
- *University of Kentucky Behavioral Health Satisfaction Tool for Outpatient Consumers*
  This tool includes three instruments and is annually administered to 5% of consumers served:
  - Kentucky Consumer Satisfaction Survey;
  - The 21 item Mental Health Statistics Improvement Program Survey; and
  - Medical Outcomes Study Health Status Survey.
- *Medical Outcomes Study Health Status Survey*
  Completion of this tool is voluntary for consumers who have severe mental illness and are served through Therapeutic Rehabilitation Programs.

PERFORMANCE INDICATOR 1

Goal: To increase access to services for adults with severe mental illness.

Target: Increase the percentage of adults with SMI who receive services from the Regional Boards from 36.3% to 38.5%.

Population: Adults with SMI

Criterion: 2

Performance Indicator: Penetration Rate--Adults with Severe Mental Illness

Value:	Percent
Numerator:	Number of adults with SMI served by the Regional Boards.
Denominator:	2.6% of the total number of adults per Kentucky 2000 census.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the steady increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SMI marker in the MIS.

Performance Indicator 2

Goal: To increase access to services for adults with severe mental illness.
Target: Increase the percentage of adults with SMI who receive services from the Regional Boards.
Population: Adults with SMI
Criterion: 2
Performance Indicator: Penetration Rate--Older Adults with Severe Mental Illness

Value:	Percent
Numerator:	Number of adults age 60 and over, with SMI, who received services from the Regional Boards.
Denominator:	2.6% of the total number of adults age 60 and over per Kentucky 2000 census.

Sources of Information: MIS data is used for actual numbers of adults. Department staff also utilize information provided by the Regional Boards (Plan and Budget Form 122 & 123) to set targets.
Significance: Kentucky's older adult population is the fastest growing segment of the population and older adults with SMI often do not seek the services they need.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

ACTION PLANS

Criterion 2

Component 1: SMI Prevalence

A review of the information from the SFY 2006 regional plans reveal that:
- All fourteen regions described their process for coding SMI.
- Only two regions exhibit variances of more than one standard deviation from the statewide average (penetration rate) and are actually higher than the statewide average. This is an improvement over last year when one-half of the regions were out of range (more than one standard deviation from the statewide average).

A wide variety of penetration rates is apparent across the state and it appears that the diversity is due to the availability of alternative resources. For instance, in an urban area, private psychiatric providers would likely be utilized by a higher proportion of adults with severe and persistent mental illness, than would be the case in rural areas. However, the variation in penetration rates, reported by the Regional Boards, does not lend itself to this interpretation. The Department has an interest in applying a consistent definition of "adults with severe mental illness" to improve the quality of information on this priority population. Accuracy of coding is monitored by medical record reviews during periodic Status Assessments of mental health services provided by Regional Boards.

In addition, statistical indicators that rely on the number of adults with an SMI marker are increasingly used to assess performance and outcomes. As a result, Regional Boards and the Department are increasingly interested in the consistent and accurate use of the marker in their data sets.

As the KDMHMRS moves toward the use of performance indicators and performance contracting, the issue of identifying individuals with severe mental illness in clinical records and in the client data set becomes increasingly important.

Regional Boards have adopted a number of strategies to more accurately identify individuals as meeting the KDMHMRS definition of severe mental illness. These include:

- Increased training of clinicians;
- Routine chart reviews;
- Changes in intake and update procedures.

❖ **State Objective A-2-1:** Continue to collaborate with Regional MHMR Boards in exploring their processes for accurately and consistently identifying adults with severe mental illness who receive community mental health services.

Component 2: Mental Health Data

Uniform Reporting System - Kentucky can report overall 62% completion and 38% partially completed on the 21 tables. Figure 1 provides a glance at the status of Kentucky reporting in the Uniform Reporting System tables. The majority of the 38% partially completed tables pertain to evidence-based practice information. In recognizing the need for continued assistance in this area, SAMHSA has developed a workgroup to study further what evidence-based practice information is needed at the Federal level and what related evidence-based practice information states can submit. This workgroup has stated that the information requested in the current evidence-based practice tables may change in the upcoming years. Kentucky will make every effort to attain the information as requested in the tables. One step toward doing so is that our State Planner participates in the Evidence-Based Practice Workgroup conference calls.

Quality Assurance - Currently, the Division of Mental Health has a process that facilitates information exchange and maintains continuity and relational values among data sets. The Joint Committee on Information Continuity (JCIC) is the committee that establishes policies and procedures for this purpose. In addition, with the recent reorganization of KDMHMRS a new Quality Assurance Branch has been created that will focus on the development of standards and measurement of outcomes for the entire department.

Resources Needed to Implement Evidence-Based Practices -Currently, additional resources are needed to support more extensive use of clinical evidence based practices. Kentucky currently does not have in clinical practice several of the evidence based practices as listed in the Uniform Data Reporting System.

Costs - Processes developed for applying the BPRS and the MCAS are in place so that instrument usage stands alone of any further shrinking of available resources. The application of the MHSIP Consumer Survey is currently being conducted as a result of the Data Infrastructure Grant. Kentucky will plan to work with Regional Boards to set in place a process to annual collect and process the MHSIP survey data as well as reduce the Boards' costs of having to meet related JACHO requirements.

Identification of Clients - Currently, the Cabinet can not identify clients served in order to conduct quality performance surveys such as the MHSIP Consumer Survey. Having access to this information means further working with the contracted Regional Boards and adjusting data base structures to include this information.

Data Warehouse - Linking mental health data with other agency data such as public health, education, or justice system currently requires project level Memorandum of Agreements. Kentucky would like to work toward establishing a data warehouse to make available information to agencies who share common goals.

Analysis of Multiple Data Sets - The Division of Mental Health and Substance Abuse Services is working with the Department for Community Based Services (DCBS), the Department for Public Health, Department of Corrections and the Department for Juvenile Justice to develop methods for sharing data without breaching confidentiality. Utilization of private psychiatric hospital beds by Regional Board clients is a major subject for analysis during the coming fiscal year. Comparison of data on children by DCBS and children served by KDMHMRS is also planned to assist DCBS in complying with their federally-recognized Performance Improvement Plan. Additionally, involvement in the criminal justice system by adults and children is the subject of another study. These efforts are part of the federally funded "Data Infrastructure Grant" project.

Uniform Reporting System - Kentucky is applying for the State Data Infrastructure Grant in order to accomplish the three objectives:

- To be able to complete 100% of Uniform Reporting System tables (21) by September 2007;
- To continue to improve the quality of the data submitted by the Providers (14 Regional Boards). This includes continued work with the Research and Data Management Center and the Joint Committee for Information Continuity to improve data reporting in the areas of accuracy and completeness. This also includes regular consultation with a group of Quality Improvement Specialists;
- To further develop outcomes goals within the Division of Mental Health. In addition to having access to the completed Uniform Reporting System data tables, the Division has established performance measures for use in understanding the effectiveness of service delivery across Kentucky. The next step is using this information to develop a deeper understanding of improving service delivery. The Division would like to be able to make further use of the variables collected to benefit community-based delivery systems. The first step includes setting outcomes goals.

Quality Assurance for Outcomes

- The first step to assuring quality outcomes begins with goal three in the above section related to the establishment of Division-wide outcome goals. Second, the Department will to establish a committee for establishing procedures for Quality Assurance as related to outcomes. This committee will most likely involve consumers, Regional Boards, and Department staff.

State Objective A-2-2: KDMHMRS will monitor the MIS for accurate reporting of data.

Comments from the Mental Health Planning Council meeting on August 18, 2005:
There were no comments for this Criterion.

Criterion 4: Targeted Services to Homeless and Rural Populations

The plan provides for the establishment and implementation of outreach to, and services for, such individuals who are homeless and the manner in which mental health services will be provided to individuals residing in rural areas.

Goal: Improve outreach and services to persons who are homeless or live in rural areas of the Commonwealth

Component 1: Homeless Outreach

Regional Perspective
Most Regional Boards offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Regional Boards report in their system of care plans for adults with severe mental illnesses the following level of participation:

- All Regions participate in regional Continuum of Care routine meetings;
- All Regions give a service priority to homeless individuals;
- Seven Regions have staff dedicated to homeless individuals;
- Four Regions do street outreach;
- Eight Regions regularly visit local homeless shelters;
- Nine Regions do consultation with local shelters; and
- Eight Regions have a walk-in clinic.

State Perspective
By combining PATH and other McKinney funds (that support specialized services) with state and federal funds (that support Community Support Services), KDMHMRS and the Regional Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with severe mental illness who are homeless. The role of the State PATH Coordinator is central to supporting local PATH providers throughout Kentucky. The Coordinator prepares the annual PATH application in collaboration with local providers, insures that annual data collection requirements are met, and insures that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homeless issues, and on-site technical assistance as needed.

KDMHMRS collaborates with the Specialized Housing Resources Department within the Kentucky Housing Corporation (KHC) in the maintenance of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen mental health regions). Regional Boards are encouraged to participate in this process for the benefit of individuals with severe mental illness who are homeless or may become homeless in their regions.

KDMHMRS provides state funds to the St. Johns' Day Center in Louisville to hire an outreach worker. This staff person provides on-site assessment and links individuals with services at Seven Counties Services, the Regional Board for Louisville. During SFY 2006, CMHS Block Grant funds will continue to support a Rural Homeless Outreach program in the Mountain Regional Board area. The goals of this program will be the identification and linkage of individuals with serious mental illness who are homeless with mainstream mental health services and the provision of consultation and training to homeless service providers. The service providers will primarily be members of the region's Continuum of Care group charged with developing regional, collaborative strategies to serve the homeless.

KDMHMRS has collaborated with the Kentucky Council on Homeless Policy in developing a Statewide Homeless Prevention Plan. This plan is designed to adopt policies and strategies to improve access to mainstream services for people experiencing homelessness. Recommendations include such areas as:

- Coordination of services;
- Planning Strategies;
- Procedural processes;
- Training needs; and
- Funding.

KDMHMRS has also been collaborating with the Kentucky Council on Homeless Policy in developing a ten-year plan to end chronic homelessness in Kentucky. Staff within the Division of Mental Health and Substance Abuse have played a principal role in identifying barriers to receipt of mainstream mental health and substance abuse services by individuals who have been chronically homeless. Recommendations include such areas as:

- Affordable Housing;
- Services;
- Discharge Planning;
- Coordination of Resources; and
- Economic Limitations.

Performance Indicators and Action Plans are found at the end of this Criterion

Component 2: Rural Outreach

Regional Perspective

A number of initiatives have been established at the Regional Board level to address rural issues. CMHS Block Grant funds continue to be allocated to rural areas to maintain housing developer positions. These staff persons are responsible for improving access to existing housing as well as developing additional housing opportunities for adults with severe mental illness. Rural housing developers have been focusing on applying for and administering set-asides of rental assistance funding to be targeted to adults with mental illness residing in rural counties. A number of housing funding sources have been accessed including HOME funds, Emergency Shelter Grant funds and Shelter plus Care funds. These initiatives have allowed Regional Boards to tailor rental assistance programs to local needs.

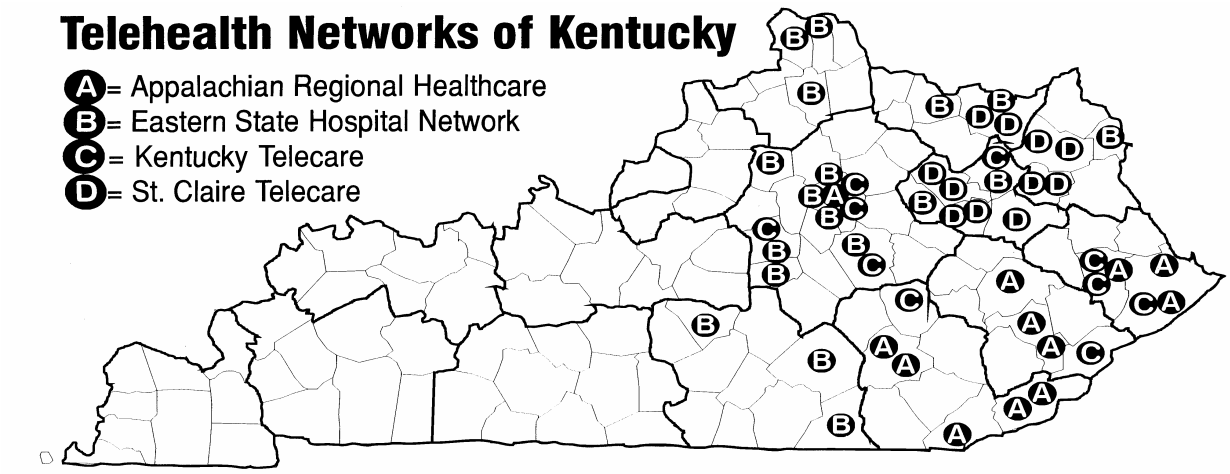
Ten of fourteen Regional Boards report engaging in initiatives to better coordinate transportation services in their regions. The Bluegrass Regional Board maintains a teleconferencing/telepsychiatry network across the four regions within the Eastern State Hospital district. Telehealth is used for discharge planning meetings between ESH and outpatient offices. The University of Kentucky is also using telemedicine to communicate with local clinics in Eastern Kentucky. An initiative of the 2000 Kentucky General Assembly established a Telehealth Board, which established standards and enabled billing for telehealth services.

Four Regional Boards now report delivering or accessing services from the telehealth network and for very limited uses (e.g. screening for case management services upon discharge from state facilities).

- Pathways, Inc., has obtained the equipment and is looking at using this in remote counties;
- Kentucky River Community Care, Inc., has several sites equipped for video conferencing. Two sites are a part of the Appalachian Regional Healthcare network and one site is a part of the Centernet network. They have business meetings, Olmstead meetings, case conferences, trainings and other events over these networks but have not started providing direct client services over these networks since protocols have not yet been established;

- Bluegrass Regional Board uses Telehealth for discharge planning meetings between ESH and outpatient offices, and is finalizing billing instructions to enable an expanded use of this service. Bluegrass also utilizes trainings from the University of Kentucky's TeleHealth network for continuing education of staff and general grand rounds.

A map showing the availability of “telehealth” in eastern Kentucky, where access is most problematic, may be found below.



State Perspective

Using the definition of Standard Metropolitan Statistical Area, and information from the 2000 Census, Kentucky has 27 counties considered urban and 93 considered rural. Approximately 44% of the state’s population resides in its 93 rural counties.

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of 16 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number.

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens centers, church groups, and government agencies. Rural case managers have been resourceful in assisting persons with a severe mental illness in identifying their needs, as well as meeting these needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Several actions by the Kentucky General Assembly have increased the types and numbers of mental health professionals who can be a Qualified Mental Health Professionals and created licensure for mental health counselors. The KDMHMRS will continue to work with rural communities and other entities in these activities including addressing shared federal, state, and local funding, shared and cross training; and bringing all stakeholders together at the state and local level to strategize best practices.

The advantages of establishing a teleconferencing capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, teleconferencing can be used to extend staff coverage from a central site to outlying rural clinics and other service sites. Specialized services (e.g. therapists who are fluent in sign language) could be effectively extended through the use of teleconferencing.

Consumers, family members and providers can access resource information via the Internet at KyCares (www.kycares.ky.gov), the online services/information directory and guide for Federal, State and Community Providers, which provides information on basic services like housing, food, childcare, transportation, benefits information, and any number of physical health and behavioral health services.

During SFY 2006, statewide consumer and family initiatives will continue to receive CMHS Block Grant funding to continue to impact on the problems associated with rural isolation, stigma, lack of information and access**:**

- The Kentucky Consumer Advocacy Network's Bridges Program will continue to provide peer support in several rural areas;
- NAMI Kentucky will provide "Family to Family" education in rural counties. A statewide campaign with the faith community has been developed to heighten awareness of the special needs of families and consumers in rural areas. In addition, the Crisis Intervention Team program will be expanded to include rural areas; and
- NAMI Kentucky will target two rural areas for establishment of new local affiliate organizations.

PERFORMANCE INDICATOR 1
Goal: Improve outreach and services to persons who are homeless or live in rural areas of the Commonwealth.
Target: It is anticipated that in 2006 Regional Boards, of the adults with SMI, 3.3% of them will be homeless.
Population: Adults with SMI
Criterion: 4
Performance Indicator: Penetration Rate—Adults with SMI Who Are Homeless.

Value:	Percent
Numerator:	Number of adults with SMI, served by the Regional Boards, who have living arrangement demographic field of " homeless/uninhabitable dwelling" or mission/shelter."
Denominator:	2.6 percent of the 2000 Kentucky adult census served by the Regional Boards.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: Regional Boards first reported the demographic for homelessness in 2004. The homelessness population in Kentucky is reportedly growing and national literature indicates that many of them have unmet mental health treatment needs.

PERFORMANCE INDICATOR 2
Goal: Improve outreach and services to persons who are homeless or live in rural areas of the Commonwealth.
Target: It is anticipated that the number of adults with SMI who reside in rural areas will be approximately 45% in 2006 .
Population: Adults with SMI
Criterion: 4
Performance Indicator: Penetration Rate—Adults with SMI Who Reside in Rural Areas of the State.

Value:	Percent
Numerator:	Number of adults with SMI, served by the Regional Boards, who reside in rural (non-MSA) counties.

Denominator:	2.6 percent of the 2000 Kentucky adult census who reside in rural (non-MSA) counties.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system. University of Louisville's Data Center is the source of MSA versus non-MSA Kentucky counties.
Significance: This is considered a valuable indicator of the population served and it is representative of the steady increase in demand for services in rural areas. The targets for last year and this year are modest due to the recent (and potentially continuing) changes in which counties of the state are considered rural (non- MSA) versus non-rural.
Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

STATE ACTION PLANS

CRITERION 4

Homeless Outreach

The Kentucky Housing Corporation's (KHC) Housing Needs Assessment 2004 estimates the homeless population to be approximately 1% of the total population, and KHC's Homeless Survey 2001 reported approximately 17% of homeless respondents identified a serious mental illness. With population figures from the 2000 Census, there are an estimated 30,471 homeless adults in Kentucky, and **5,180 homeless adults with a serious mental illness** (at some point in time during a 12 month period). The following table shows this information broken down by region.

Regional Boards*	Adult Census 2000	Homeless Estimation	Homeless SMI Estimation
1. Four Rivers	157,510	1,575	268
2. Pennyroyal	154,361	1,544	262
3. River Valley	155,001	1,550	264
4. Lifeskills	193,083	1,931	328
5. Communicare	177,804	1,778	302
6. Seven Counties	654,224	6,542	1,112
7. Northkey	286,137	2,861	486
8. Comprehend	41,452	415	71
9/10. Pathways	162,796	1,628	277
11. Mountain	121,476	1,215	207
12. Kentucky River	91,201	912	155
13. Cumberland River	177,872	1,779	302
14. Adanta	147,152	1,472	250
15. Bluegrass	526,882	5,269	896
Total	**3,046,951**	**30,471**	**5,180**

The Kentucky Council on Homeless Policy has identified the following barriers to decreasing homelessness.

- Lack of knowledge about the types of resources and process for access;
- Difficulty in keeping existing databases and information sources up to date;
- Non-uniform accessibility to resources in each region;

- No central point of contact for becoming aware of or accessing available resources either at the state or local level;
- No shared philosophy among all social service workers of prevention approach; and
- Difficulty "mainstreaming" homeless persons with severe mental illness into regular mental health programs and other community services operated by Regional Boards and other community agencies.

Additional barriers include:
- No state funds are provided for homeless services;
- Limited residential options that combine permanent housing with on-site supports;
- Although Kentucky received an increase in PATH funding, to $393,000, it is insufficient to address the needs of homeless persons with mental illness in the state.

Priorities identified by the Kentucky Council on Homeless Policy and KDMHMRS include:
- Continued participation in HUD's Continuum of Care process, with increased coordination between agencies;
- Continued outreach to homeless persons with a mental illness;
- Decrease discharges from inpatient facilities to homeless shelters; and
- Expansion of the state PATH program.

During SFY 2006 KDMHMRS will, through the PATH Formula Grant, support specialized initiatives to complement the existing community support array in the three urban regions (Lexington, Louisville, and Covington) and two rural regions (Kentucky River and Adanta). PATH programs will provide the following services:
- Outreach, housing, case management and psychiatric clinic services in a large homeless shelter in Lexington;
- Outreach, housing and psychiatric clinic services in Covington;
- Payee ship and case management services within a homeless service organization in Covington;
- Residential support within a transitional facility for homeless men with severe mental illness in Louisville;
- Case management and residential support in the Kentucky River Region; and
- Outreach and housing support services in the Adanta Region.

KDMHMRS staff and Regional Board staff use a number of strategies to insure that individuals with serious mental illnesses who are homeless are evaluated and receive necessary services. These include:
- Identifying individuals who have been homeless more accurately in the client data set;
- Providing accommodations in clinic and other program hours;
- Providing specialized training to case managers and clinicians;
- Establishing formal and informal linkages with homeless services providers; and
- Continued participation in local Continuum of Care meetings.

❖ **State Objective A-4-1:** Collaborate with homeless service providers and other state agencies in implementing the Homeless Prevention Pilot Project, to address the problem of institutional discharge to homelessness.

Rural Outreach

The President's New Freedom Commission on Mental Health recommends improving access to quality care in rural and geographically remote areas. The Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnosis (HB 843)

recommends addressing the issues of transportation, the availability of trained professionals, and the availability and utilization of telehealth and distance learning technology to reduce the isolation in rural areas.

Common problems for rural areas are isolation and the difficulties imposed by the lack of information and access. Lack of adequate transportation, and in some regions, lack of any public transportation remains the largest barrier to services. Other problems include the heightened stigma associated with mental health services in rural areas and the difficulty in ensuring confidentiality and anonymity in small communities. Regional Planning Councils of the HB 843 Commission identify a lack of sufficient funding and a scarcity of trained professionals as barriers to services in their regions.

Priorities include:

- increasing access to services by increasing transportation opportunities;
- increasing availability of trained treatment professionals;
- increasing public awareness of mental health services; and
- increasing availability and utilization of telehealth to reduce isolation.

❖ **State Objective A-4-2:** Incorporate best practices in rural service delivery into existing KDMHMRS sponsored training events (e.g. MHI, CSP Director, Level II Case Management).

Comments from the Mental Health Planning Council meeting on August 18, 2005:
There were no comments for this Criterion.

Criterion 5: Management Systems

The plan describes the financial resources and staffing necessary to implement the requirements of such plan, including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health. The plan contains a description of the manner in which the state intends to expend the grant for FFY 2004 to carry out the provisions of the plan.

Goal: To assure that the recovery oriented mental health system has:

- ***An adequate number of mental health professionals***
- ***A culturally competent workforce***
- ***Adequate and appropriate training of mental health professionals***
- ***Adequate financial resources***

COMPONENT 1: Staffing Resources

Regional Perspective
Community mental health services in Kentucky are provided by Regional Boards, which are non-profit corporations employing approximately 4000 persons statewide. A small segment of this workforce works exclusively with adults with severe mental illnesses in community support programs. In the recent Plan and Budget submission, Regional Boards were asked to identify staff dedicated to serving adults with severe mental illnesses.

These Community Support Program (CSP) staff include the following:

Region	**SMI Served**	**Case Mgmt.**	**Therapeutic Rehabilitation**	**Outpatient Therapists**	**Total Dedicated CSP Staff**
1	861	6	5	19	11
2	1471	8	5	20	13
3	1623	9	14	4	18
4	2532	16.5	14	51	30.5
5	692	7	17	3	27
6	4959	52	9	49	110
7	1618	6	8	12	14
8	219	3	5	16	8
9/10	1874	12	61.7 *	61.7 *	77.7
11	2170	24	24	17	66.5
12	1290	12	15	6	28
13	1160	9	13	75.5	22
14	2132	17	28	42	45
15	3163	19.8	46.72	179	280

*Combined total of TR and Outpatient staff.

State Perspective
Human resource development is a key component in crafting a quality system of care. The issue of "staffing" is affected by a number of factors including regulations, provider qualifications, training, recruitment and retention. Although the Department does not directly employ or manage the staff of the Regional Boards, the Department is responsible for planning for a workforce to meet the demand for services. Traditionally the Department's role has been indirect, focusing on staff training, technical

assistance and the establishment of minimum qualifications for providers. The Department continues in these roles but has taken on a larger, more direct role in addressing the shortage of behavioral health care providers in the state.

Component 2: Cultural Competency

Regional Perspective
In general, the majority of regions have specially trained staff, who in turn provide cultural competency training at orientation for new staff. Cultural competency is assessed through consumer satisfaction surveys and supervision of employees.

State Perspective
Building on efforts first initiated in SFY 97, the Department remains firmly committed to promoting and supporting a culturally competent workforce throughout its service delivery system (central office, the state operated or contracted facilities and the Regional Boards). To this end, the Department contracts with two highly acclaimed cultural competency trainers to provide "Training of Trainers" courses at least twice a year to staff from Regional Boards and facilities. These courses are based on a continually evolving curriculum developed by the Department and are held at varying locations throughout the state. This strategy has been very favorably received by the Regional Boards and facilities as it allows them to develop their own internal cultural competency training capacity, as well as minimizing out-of-office time on the part of staff and related travel expenses.

Component 3: Major Training Initiatives

Regional Perspective
A review of the information from the SFY 2006 regional plan applications reveals that:
- Twelve of the Regional Boards offer specialized training opportunities to CSP staff;
- Five Regional Boards now have 21 staff that have earned IAPSRS certification; and
- Ten regions have ongoing training initiatives with local colleges or universities that are described in their annual plans.

As one component of the "decriminalization" of mental illness, each Regional Board is responsible to provide education programs to peace officers, emergency service providers, courts, and inpatient psychiatric facilities in their region. Topics included are an overview of the involuntary hospitalization law, the consumer's need for privacy, the importance of using the least restrictive level of restraint, and how to access evaluators 24 hours a day, seven days a week. A curriculum based on the initial decriminalization training for peace officers is included in the yearly training provided to each peace officer in Kentucky, and is included in the training of adult protective service workers for the Cabinet for Families and Children.

State Perspective
KDMHMRS provides, sponsors, or participates in a variety of training initiatives. This includes sponsoring continuing education units (CEUs) for professional board licensure and certification. Many of these initiatives have been referenced in preceding sections but are discussed in detail below.

On an annual basis the Division of Mental Health provides a number of training events. These include:

Division of Mental Health and Substance Abuse Sponsored/Provided Training Events

Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
Case Management Certification Training	Mental Health Case Managers who work with Adults with SMI and their supervisors	Approximately 30 per session	Held 4 times per year for 3 days each
*Mental Health Institute Pre-Conference on Medication Algorithms	Behavioral health providers and administrators, consumers and family members	Approximately 1,000 Approximately 300	Annually 2.5 days 9/27-29/05 9/26/05
*Kentucky School of Alcohol and Other Drug Studies	Behavioral health providers and administrators, consumers and family members	Approximately 1,000	Annually 4.5 days 7/18-22/05
*Question, Persuade, Refer (QPR) Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Varies depending on location across the state	At least four times per year
*Cultural Competency Training of Trainers	Current and prospective providers of Cultural Competency Training at the KDMHMRS operated or contracted facilities and Regional MH/MR Board staff and KDMHMRS central office staff	Approximately 20	Four times per year and upon request
Train the Trainers Suicide Prevention in the Jails	Jailers and Regional MH/MR Board staff	Varies depending on location across the state	At least two times per year
Deaf Awareness Trainings	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
TTY Assistive Listening Devices Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
What Is Mental Health Training	Kentucky Association for the Deaf	Up to 200	Annually
Domestic Violence and Deafness Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Approximately 60	Annually
*HIV/AIDS Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Annually

Case Management Certification Training

This certification training is provided by KDMHMRS and Kentucky Medicaid staff with the assistance of consumers, family members and staff from Regional Boards. The training is provided four times per year, in two regions of the state. To assist with the development and implementation of case management training activities, a Case Management/Service Coordination Advisory Committee, composed of a faculty of case managers, supervisors, consumers, family members, and advocates, was developed in 1993. This advisory committee meets quarterly and provides vision, technical assistance, training opportunities, curriculum development, and direction for mental health case management services in Kentucky. An additional training curriculum has been developed and expanded to include advanced courses for the experienced case manager (Level II) and specialized training for case management supervisors.

Mental Health Institute
The Department hosts an annual conference called the Mental Health Institute for approximately 1,000 Regional Board providers, family members, and consumers. The Institute is a major source of continuing education for behavioral health professionals employed by the Regional Boards.

Jailer Training
During SFY03 the Department received new state funding to train staff in each of the 80 jails in the Commonwealth on suicide prevention and mental health issues. In addition, training is provided to jail staff on accessing and utilizing the Kentucky Jail Crisis Triage System.

PASRR Training
The Department sponsors PASRR certification training for staff of the Regional Boards who provide PASRR Level II evaluations for persons seeking admission to nursing facilities. The Department also sponsors PASRR skills training through a contract with the University of Kentucky Sanders-Brown Center on Aging.

Leadership Academy
The Office of Consumer Advocacy within KDMHMRS sponsors a Leadership Academy for consumers who want to develop their leadership potential. More recently a train-the-trainers event has also been added to increase capacity for this popular training.

Cultural Competency Training
The Department sponsors cultural competency "train-the-trainers" sessions twice per year for interested Regional Board and facility staff. The training uses a curriculum developed in SFY 97. Additionally, two seminars targeted for KDMHMRS central office staff are also provided on an annual basis.

Community Support Services Training
KDMHMRS staff convenes quarterly meetings of directors of Community Support Services programs and staff. These meetings and other training events are ideal settings for the provision of innovative training in evidence based practice and technical assistance from state and national experts in the areas of rehabilitation and recovery, continuity of care, housing, crisis response systems, dual diagnosis and more.

Deaf and Hard of Hearing Training
The KDMHMRS Statewide Coordinator for Deaf and Hard of Hearing Services, along with a new Program Coordinator staff member, continue to provide on-going statewide training, technical assistance and consultation regarding the provision of mental health services and communication with persons who are deaf or hard of hearing. Continued training of Deaf awareness and correct TTY usage is also provided. Additionally, training to inform and empower the deaf and hard of hearing community regarding their rights to services and how to obtain needed, appropriate services is ongoing. Accessing and using technology remains an important aspect of all contacts with providers and consumers.

Training of Emergency Services Personnel
To build on this successful initiative, KDMHMRS uses Block Grant funds to partner with NAMI Kentucky to fund a cross-systems training coordinator. This position works across multiple systems (including mental health, mental retardation, substance abuse, corrections, criminal justice training, jailers association, and Kentucky State Police) to advocate for and coordinate training modules for police officers that encounter persons with severe and persistent mental illness. This position is also developing training curriculums for other first responders including emergency medical responders and judges.

Suicide Prevention Training
As part of Kentucky's Plan to respond to the Surgeon General Call to Action to address suicide prevention, the Kentucky Suicide Prevention Planning Group was formed in 2002 and identified a model training that is being offered in several venues across the state. "Q.P.R" Question, Persuade, Refer was adopted by the group as a model training for everyone related to suicide. Certification training was provided to over 30 individuals from various areas of the community by Dr. Paul Quinett in the fall of 2003. This certification of trainers will continue in SFY 2006. In addition, KDMHRS will host a statewide Suicide Prevention Conference in September of this year.

Component 4: Financial Resources

Regional Perspective
Regional Boards have not been able to avoid the budgetary constraints that the Commonwealth has experienced. Some of the specific challenges they have been faced with include:

- A cut in state general fund dollars (2.5% in SFY 2004 and an additional cut of 2.5% in SFY 2005);
- Increased costs associated with payment of health insurance for staff;
- Increase in employer contributions towards staff retirement funds.

In addition, the state hospitals have experienced budgetary cuts and have been faced with a reduction of staff and subsequent bed capacity. The loss of private inpatient beds in communities, has also placed an increasing demand on the boards to provide less restrictive levels of services with no additional resources to manage the demand.

Although there has been an increased effort by KDMHMRS to allow for much more flexibility in planning for service over the last three years, it continues to be challenging to the boards to meet the increasing needs without substantial increases in revenue.

State Perspective
KDMHMRS does not provide direct community-based services, but assures the delivery of services through contracts with the fourteen Regional Boards.

CMHS Block Grant funds are subcontracted by the Department to the Boards based on an approved Plan and Budget. The Plan and Budget is the basis for the contractual agreement between the Department and a Regional Board to provide services that are consistent with fund source requirements, departmental priorities, service definitions and standards. Regional Boards may subcontract with appropriate community agencies to provide the contracted services.

SFY 2006 Financial Resources Summary – Adult Services

The following table summarizes the financial resources available for SFY 2005 to support the comprehensive array of adult mental health services:

SFY 2006 ALLOCATIONS	
Fund Source	**Amount**
Restricted MH General Fund & Decriminalization	$12,033,611
Flexible MH General Fund & Community Care Support	$13,512,554
CMHS Block Grant	$3,921,596
PATH	$352,000
PASRR	$1,066,900
Community Medications	$5,373,100
Personal Care Homes (MHGF)	$7,445,666
Housing	$1,016,901
Acquired Brain Injury	$2,470,662
Olmstead Wraparound	$800,000
Other Federal funds	$332,888
Medicaid	$50,520,942
Other Local	$14,956,246
Total Adult Allocations	$113,803,066
Funds allocated for services to either Adults or Children ($726,281) are not included in the above total.	

SFY 2006 CMHS Block Grant Allocations

The following table illustrates CMHS Block Grant allocations for services to adults with severe mental illness in SFY 2006 listed by the components of the array discussed in Criterion 1:

Component	Block Grant Amount
Consumer and Family Support	$733,968
Emergency Services	$219,357
Mental Health Treatment	$131,099
Specialized Mental Health Treatment	$2,558,093
Other (Training, Planning, etc.)	$344,549
Total SMI	**$3,987,066**
CMHS Block Grant Funds allocated to REGIONAL BOARDS for services to either Adults or Children ($162,445) are not included in the above total.	

SFY 2006 Funded Entities – Adult Services

The table below shows SFY 2006 CMHS Block Grant funding by funded entity.

TABLE A	
Region/Contract	**Amount of Adult CMHS Award for SFY 2006/FFY 05**
1 – Four Rivers	$136,201
2 – Pennyroyal	183,823
3 – River Valley	201,443
4 – LifeSkills	289,935
5 – Communicare	149,778
6 – Seven Counties	963,555
7 – NorthKey	288,515
8 – Comprehend	35,731
10 – Pathways	234,822
11 – Mountain	182,607
12 – Kentucky River	80,045
13 – Cumberland River	251,551
14 – ADANTA	124,853
15 – Bluegrass	430,856
KHC	13,334
Corrections	50,000
Voc Rehab	75,000
EKU	251,990
UK	23,027
TOTAL	**$3,987,066**
*Funds allocated to provide MH services For either Adults **or** Children (not included above)*	$162,445

A list of funded entities is provided on the following page. These entities will be funded with FFY2004 and FFY 03 Carryover funds consistent with priorities of the Mental Health Services Planning Council and the KCMHMRS plan and budget process.

Funded Entities

Regional MH/MR Boards

Region 1
Four Rivers MH/MR Board, Inc.
425 Broadway, Ste 201
Paducah, Kentucky 42002-7287

Region 2
Pennyroyal Regional MH/MR Board, Inc.
P O Box 614
Hopkinsville, Kentucky 42241-0614

Region 3
River Valley Behavioral Health
P O Box 1637
Owensboro, Kentucky 42302-1637

Region 4
LifeSkills, Inc.
P O Box 6499
Bowling Green, Kentucky 42101-6498

Region 5
Communicare, Inc.
107 Cranes Roost Court
Elizabethtown, Kentucky 42701

Region 6
Seven Counties Services, Inc.
101 W. Muhammad Ali Blvd.
Louisville, Kentucky 40202

Region 7

NorthKey Community Care
P O Box 2680
Covington, Kentucky 41012

Region 8
Comprehend, Inc.
611 Forest Avenue
Maysville, Kentucky 41056

Region 9/10
Pathways, Inc.
P O Box 790
Ashland, Kentucky 41100

Region 11
Region XI (Mountain Comp. Care Center)
104 South Front Ave.
Prestonsbug, Kentucky 41653

Region 12
Kentucky River Community Care
P O Box 794
Jackson, Kentucky 41339-0794

Region 13
Cumberland River Comp. Care Center
P O Box 568
Corbin, Kentucky 40702

Region 14
The ADANTA Group
259 Parkers Mill Road
Somerset, Kentucky 42501

Region 15
Bluegrass Regional MH/MR Board, Inc.
1351 Newtown Pike
Lexington, Kentucky 40515

Other Funded Entities

University of Kentucky Research Foundation
109 Kinkead Hall
Lexington, KY 40506-0057

Kentucky Dept. of Corrections
State Office Building - 5th Floor
Frankfort, KY 40601

Cabinet for Workforce Development/OVR
Capital Plaza Tower
500 Mero St.
Frankfort, Kentucky 40601

Kentucky Housing Corporation
1310 Louisville Road
Frankfort, Kentucky 40601

Eastern Kentucky University
100 Stratton Building
Richmond, Kentucky 40675

PERFORMANCE INDICATOR 1

Goal: To assure that the recovery oriented mental health system has: An adequate number of mental health professionals; A culturally competent workforce; Adequate and appropriate training of mental health professionals; and Adequate financial resources.
Target: It is anticipated that 38% of funding will support community based services.
Population: Adults with SMI
Criterion: 5
Performance Indicator: Community Service Proportion of State Mental Health Funding

Value:	Percent
Numerator:	Mental Health allocations to the Regional Boards minus the allocations for privatized state supported hospitals and personal care homes.
Denominator:	Total KDMHMRS mental health allocations to the Regional Boards and state personal care homes.

Sources of Information: Allocations as designated to each of the Regional Boards and review of their reported expenditures at year end. Not all regions have submitted their financial implementation reports in time for incorporation in this report.
Significance: This is considered a valuable indicator of the resources available to meet an ever increasing demand for services. The amount available to serve Kentucky's adults with SMI in the community is considered inadequate to meet the need.

Performance Indicator 2

Goal: To assure that the recovery oriented mental health system has: An adequate number of mental health professionals; A culturally competent workforce; Adequate and appropriate training of mental health professionals; and Adequate financial resources.
Target: A projection of $32.65 is anticipated for this indicator for 2006.
Population: Adults with SMI
Criterion: 5
Performance Indicator: Per Capita State Mental Health Expenditures

Value:	Percent
Numerator:	Annual KDMHMRS mental health dollars allocated to the Regional Boards, state hospitals, and personal care homes.
Denominator:	The Kentucky 2000 census.

Sources of Information: Allocations as designated to each of the Regional Boards and review of their reported expenditures at year end. Not all regions have submitted their financial implementation reports in time for incorporation in this report.
Significance: This is considered a valuable indicator of the resources available to meet an ever increasing demand for services. The amount available to serve Kentucky's adults with SED is below the national average.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

STATE ACTION PLANS

Component 1: Staffing Resources
A number of trends and challenges make recruiting and retaining a quality workforce motivated to work in CSP programs a difficult process:

- Low pay for CSP staff, compared with outpatient clinicians;
- Lower status associated with the rehabilitation field;
- Lack of a career ladder;
- Lack of specialized training opportunities that directly relate to one's job duties;
- Limited standards of care in the CSP program; and
- Limited master's level programs in rural areas.

The Department's strategies in ensuring that the workforce is well trained have been to:
- Provide inexpensive in-service training;
- Establish linkages with universities to promote pre-service and in-service training and to facilitate recruitment;
- Develop staff certification programs in the areas of case management and geriatric assessment and to offer an extensive curriculum in the basics of clinical practice; and
- Encourage the employment of a diverse and qualified work force that is culturally competent and representative of minority persons.

The Department has worked with the state Department of Personnel to identify policies and procedures that impede the recruitment and retention of qualified staff. An agreement between the Department and the state Department of Personnel allows Regional Boards to receive names and addresses of eligible persons seeking employment in mental health professions.

Several mechanisms for collecting data are becoming available to KDMHMRS in our on-going efforts to ascertain the supply and demand of human resources statewide and to improve the recruitment and retention of mental health professionals within the state. Among them are:
- HB 843 Regional Planning Council's needs assessments;
- A study prepared for the HB 843 Commission on the availability of licensed and certified behavioral health professionals in Kentucky;
- The Olmstead State Plan Committee's strategies for collecting and improving outcomes data; and
- Strategies developed at a regional "Provider Summit" meeting attended by Kentucky representatives in November, 2000.

As a result of the HB 843 process, regional needs assessments provide a basis for assessing behavioral health human resource needs across the state. The comprehensive, point-in-time count of all certified and licensed mental health professionals in Kentucky accomplished for the Commission is now available for comparison against national rates.

Representatives of Kentucky participated in a regional Provider Summit in November, 2000 to increase the availability of behavioral health professionals for states that serve the Appalachian region. The purpose of the Summit was to promote study by states of behavioral health care provider needs and to develop strategies to improve the availability of services and providers. The Health Resources and Services Administration and Substance Abuse and Mental Health Services Administration jointly sponsored the Summit, and are making on-going technical assistance available to work groups established by participating states. Meetings continue between the Department, Regional Boards, Office of Inspector General and state higher education to promote the need for additional trained personnel.

While these initiatives are still in progress, comprehensive, accurate and valuable data are being collected that will assist Kentucky in making national comparisons and in developing meaningful plans to address human resource issues in Kentucky.

- ❖ **State Objective A-5-1:** Assist regions with developing evidenced based treatment protocols for specific mental health disorders in adults.

Component 2: Cultural Competency

There is an identified need to promote greater public awareness and recognition as to the importance of ensuring that behavioral health services are provided in a culturally competent fashion. The pertains not only to sensitivity in the areas of age, gender, race, ethnicity, religion, color, national origin, disability, and sexual orientation, but also relates to work experience, personality, geographic origin and ability and skill levels.

Due to the racial composition of Kentucky's population (91% Caucasian), there is a widely held perception that the state's population is essentially homogenous, thus making cultural competency a matter of little importance. On the contrary, Kentucky's population is quite diverse in its makeup. The largest variance within this population pertains to regional differences. The western portion of the state is largely agrarian, the Louisville and Lexington areas are urban, and the eastern portion of the state has a deep-rooted Appalachian culture. In addition, a large portion of Kentucky's African American community resides in western Louisville and near the two major military bases located in this state. Another relevant factor is the growing Hispanic segment of the populace.

- Advocate for the importance of recognizing and promoting the need to have as culturally competent a behavioral health work force that is as culturally competent as possible.
- The Department should continue to take a lead role in arranging for and providing ongoing training concerning its cultural competency curriculum.

- ❖ **State Objective A-5-2:** Continue to provide and promote at least two cultural competency "Training of Trainers" sessions each year.
- ❖ **State Objective A-5-3:** Ensure that all Department sponsored cultural competency training activities are responsive to the needs of the facilities and Regional Boards and reflect best practice approaches in this field.

Component 3: Training Initiatives

A number of challenges confront the Department and Regional Boards in our effort to develop a well-trained workforce. These challenges include:

- With constant pressures to produce "billable hours", most clinicians have very little time to devote to training, especially training that is conducted out of the office;
- The cost of sending staff to training is a deterrent to most agencies with limited budgets;
- Training in evidence-based practices is difficult to sustain as it involves a comprehensive set of skills that need to be learned and practiced over time; and
- High turnover among direct service workers forces agencies to focus on basic training topics that all staff must have.

The Department's main strategy has been to sponsor a number of free or inexpensive statewide and focused regional training events through which Regional Board staff can earn Continuing Education Units (CEUs) and obtain and maintain necessary certifications or licensures. Other strategies that are being examined include:

- Providing training through the Kentucky Virtual University or other internet based learning environments;
- Coordinating the scheduling of Departmental training and technical assistance events so that Regional Board staff do not have to travel as far or as frequently;
- Posting Department sponsored training events on the web; and
- Providing on-line registration for all training events.

- ❖ **State Objective A-5-4:** Develop a Community Support Program (CSP) training plan that identifies core topics and potential presenters, for delivery during quarterly CSP meetings, the Mental Health Institute, the Case Management Conference, and other scheduled CSP training events.

Component 4: Financial Resources

The obvious challenge for the Department is to maintain existing programs while Kentucky, along with most other states, face a growing crisis in state revenues. Other challenges include:

- Maintaining a focus on serving those most in need while allowing greater fiscal flexibility at the regional level;
- Expecting the same level of outcomes from programs that have not had an increase in funding in a decade; and
- Maintaining safety net services (e.g. crisis services) at the Regional level.

Strategies used by the Department include:

- Moving toward performance based contracting (allowing greater flexibility while holding Regional Boards more accountable for outcomes);
- Moving the focus to developing effective systems of care for adults with severe mental illnesses from developing specific program interventions; and
- Developing focused biennium budget requests that are based on a strong needs assessment, in concert with the HB 843 Commission.

- ❖ **State Objective A-5-5:** Develop a biennium budget request by August 30, 2006 that reflects the priorities established by the Mental Health Services Planning Council and the HB 843 Commission and that provides significant new funding for the "safety net" services at the regional level.

Comments from Mental Health Planning Council Meeting August 18, 2005:

Comment: Council member offered corrected information regarding changed name of entity (due to state government reorganization).
Response: Staff will ensure name and address are correct for the Office of Vocational Rehabilitation.